Tropical Smiles Dental

Melissa M Nitta, DDS

Date: _____

Patient's Sex ☐F ☐M

Patient Information

Name _____ Preferred Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Drivers License # _____ Cell Phone _____ Home Phone _____

Email _____ SSN _____

Please check the appropriate box: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Who may we thank for referring you? _____

Patient or Parent/Guardians Employer _____ Work phone _____

Spouse or Parent/Guardians Name _____ Cell Phone: _____

Person to Contact in Case of Emergency _____

Relationship to Patient _____ Cell Phone: _____

Is the patient financially responsible for their own account? ☐Yes ☐No

If no, complete the following section.

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Birthdate _____

Drivers License # _____ SSN _____

Insurance Information

Name of Insured _____ Birthdate _____

Insurance Company _____ SSN _____

Do you have any additional insurance? ☐Yes ☐No If yes, complete the following section.

Name of Insured _____ Birthdate _____

Insurance Company _____ SSN _____

75-5995 Kuakini Highway, Suite 121, Kailua Kona, HI 96740

Tel: (808) 329-1715 | Fax: (808) 329-1811

www.tropicalsmileshawaii.com

Patient Medical History

Medical Physician _____ Phone _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain: _____		
3. Do you have a persistent cough or throat clearing not associated w/a known illness (lasting more then 3 weeks)?	☐	☐
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Are you wearing contact lenses?.....	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novacaine)	☐	☐
Penicillin	☐	☐
Other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates.....	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other: _____	☐	☐
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

11. Do you have or have you had any of the following?	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever.....	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis A, B, or C/ Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Mitral Valve Prolapse	☐	☐	Other: _____	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐			

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?.....	☐	☐
3. Are your teeth sensitive to sweet of sour liquids/foods?.....	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Do you have any sores or lumps in or near your mouth?.....	☐	☐
6. Have you had any head, neck or jaw injuries?.....	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing.....	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth?	☐	☐
Do you like your smile?	☐	☐

I understand that the information that I have given today is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnoses and treatment, with my informed consent.

_____

Signature of Patient (or Parent/Guardian if Minor) Date

CONSENT FOR USE AND DISCOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME:_____

ADDRESS:_____

TELEPHONE:_____

EMAIL: _____**SOCIAL SECURITY #:**_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Tropical Smiles Dental
Melissa M. Nitta, DDS
75-5995 Kuakini Highway Ste 121
Kailua Kona, HI 96740
(808) 329-1715

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out out treatment, payment activities and health care operations.

Signature: _____**DATE:**_____

If this consent is signed by a personal representative on behalf of the patient, then complete the following:
Personal Representatives Name: _____
Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____DATE: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Tropical Smiles Dental
Melissa M. Nitta, DDS
75-5995 Kuakini Highway, Suite 121
Kailua Kona, HI 96740

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information cai and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date:**_____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority:

OTHER – SPECIFY	Names	Signatures	ID

----------For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

_____The patient refused to sign
_____Communication barriers
_____Emergency situation
_____Other

Tropical Smiles Dental
Melissa M Nitta, DDS

PATIENT TREATMENT AND FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so you may attain optimal oral health. The following is a statement of our Financial Policy, which we require you to read, agree to and sign prior to any treatment.

Since our practice is also a business with obligations that must be met, we require all patients to pay for their treatment in full on the day of each visit unless prior arrangements have been made. We accept cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit.

We will do our best to give you a close estimate of your investment in your dental health for each upcoming visit. Most estimates provided are accurate, however, as dentistry can at times be unpredictable there may be additional costs associated with treatment that we are unable to diagnose in our initial treatment plan.

As we are out of network/non-participating providers with your dental insurance company you will pay your full portion for treatment rendered to our office on the date of service. You will be provided a claim form with necessary narratives and attachments that you will mail to your insurance company and the insurance company will reimburse you directly. If the insurance company sends a check to our office, as occasionally happens, we will send you a reimbursement check for the amount paid to us.

Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors unaccompanied/accompanied by the parent or legal guardian: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed appointments and cancellations: Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 48 business hours notice for rescheduling your appointment. Your account will be charged a broken appointment fee a minimum of $85.00 for repeatedly missed appointments without proper notification.

Outstanding balances on your account must be cleared before your next appointment for any account member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amounts due and not paid in full within 30 days will be charged an interest rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement.

Delinquent balances over 90 days old will be referred to a collections agency. All referred accounts are marked “inactive”. In order to have your account “reactivated” and continue to receive dental treatment in our office, the delinquent balance plus a “Reactivation Fee” of 50% of the delinquent balance referred to the collections agency will be charged to your account. Only after this total account balance has been paid in full can appointments be made and your account and patient status be reactivated.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash or via credit card.

Billing statements may be sent to you through USPS, text message and/or email. You consent to allow utilization of all forms of billing with your signature below.

I have read and agree to the Financial and Cancellation Policy for Tropical Smiles Dental.

Patient Name: _____ DATE:_____

Patient/Responsible Party Signature: _____

75-5995 Kuakini Highway, Suite 121, Kailua Kona, HI 96740
Tel: (808) 329-1715 | Fax: (808) 329-1811
www.tropicalsmileshawaii.com

Tropical Smiles Dental

Melissa M Nitta, DDS

I hereby grant Melissa M. Nitta, DDS LLC permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Melissa M. Nitta, DDS LLC and will not be returned.

I hereby irrevocably authorize Melissa M. Nitta, DDS LLC to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge Melissa M. Nitta, DDS LLC all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHIOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW.

I ACCEPT:

Print Name: _____ Signature: _____ Date: __ / __ / ____

If under 18, both parents must sign individually and as parent/guardian.

Parent Signature: _____ | Date: __ / __ / ____

Parent Signature: _____ | Date: __ / __ / ____

I DECLINE:

Print Name: _____ Signature: _____ Date: __/__/___

75-5995 Kuakini Highway, Suite 121, Kailua Kona, HI 96740

Tel: (808) 329-1715 | Fax: (808) 329-1811

www.tropicalsmileshawaii.com