Ronald G. Packham, D.M.D.

Welcome to our practice

Patient Name: ______________________________ ___________________________________ ____

Preferred Name: ____

Birth Date: ______________ Gender: _____________ SS#: ________________________

Family Status (please circle): Married Single Child Other

Email Address:____

Phone: Home: _________________ Cell: ___________________ Work: _____________________

Address: ____

Employer Name: ____

Emergency Contact (name and phone#): ____

Whom may we thank for referring you to our practice? ____________________________________

Responsible Party Information

Please complete this section if patient is ***not*** *the guarantor*

Name of guarantor: ____________________________ ________________________________ ___

Relationship to patient: ________________________ Birth Date: _____________________

DL#: ___________________________ SS#: ________________________ Gender: ____________

Email Address: ____

Phone: Home: _____________________ Cell: ____________________ Work: ______________

Address: ____

Primary Dental Insurance

Please complete if using dental insurance. Complete only those aspects not listed above.

Subscriber Name: ________________________________ ______________________________ ____

Subscriber Birth Date: ____________________

ID#: ____________________________________ Group #: _________________________

Subscriber Address: ____

Subscriber's Employer: ____

Relationship to patient: ____

Dental Insurance Carrier Name: ____

Insurance Carrier Phone #: ____

Secondary Dental Insurance

Subscriber Name: __________________________________ _________________________ ____

Subscriber Birth Date: ________________________

ID#: ____ Group #: _________________________

Subscriber Address: ____

Subscriber's Employer: ____

Relationship to patient: ____

Dental Insurance Carrier Name: ____

Insurance Carrier Phone #: ____

Dental Health History

What is your immediate concern? ____

How would you rate the condition of your mouth? (please circle)

Excellent Good Fair Poor

Previous dentist name and phone number: ____

Date of most recent dental exam and dental x-rays: ______________________________________

I routinely see my dentist every: (please circle)

3 mos. 4 mos. 6 mos. 12 mos. Not routinely

Is there anything about your smile that you would like to change? ______________________

Check all that apply:

- o Had complications from past dental treatment
- o Had trouble getting numb
- o Had any reactions to local anesthetic
- o Had/have braces, orthodontic treatment
- o Wear a retainer
- o You experience dry mouth
- o Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- o Food gets trapped between any teeth
- o Have you ever whitened or bleached your teeth?
- o Experience popping and/or clicking of your jaw joint
- o Difficulty chewing
- o Clench or grind your teeth
- o Wear or have worn a bite appliance
- o Gums bleed when flossing or brushing
- o Treated for gum disease or were told you have lost bone around your teeth
- o Notice an unpleasant taste or odor in your mouth
- o Experienced gum recession
- o Had any teeth become loose on their own (without injury)
- o Experienced a burning sensation in your mouth
- o You snore or wake up frequently during the night

Medical History

Indicate which of the following conditions you have or have had by checking the box:

- o *Pre-Med
- o Anemia
- o Asthma
- o Arthritis
- o Artificial Joints
- o Autism
- o Blood disease
- o Cancer
- o Chemotherapy
- o Diabetes
- o Sinus Problems
- o Sjogrens
- o Stomach Problems
- o Stroke
- o Dizziness
- o Fainting
- o Epilepsy/
- o Seizure
- o Excessive Bleeding
- o Glaucoma
- o Growths/ Tumors
- o Hay Fever
- o Headaches
- o Thyroid
- o Tobacco/ Alcohol/ Drug Use
- o Tuberculosis
- o Head Injury
- o Heart Trouble
- o Hemophilia
- o High Blood Pressure
- o HIV/AIDS
- o Jaundice
- o Kidney Disease
- o Liver Disease
- o Lupus
- o Venereal Disease
- o **FEMALE**: Pregnant or Planning Pregnancy
- o Mental Disorders
- o Nervous Disorders
- o Pacemaker
- o Pre-diabetes
- o Radiation
- o Respiratory Problems
- o Rheumatic Fever
- o **FEMALE**: Nursing
- o No Medical Conditions

Do you have any **allergies (including allergies to medications)**? If yes, please explain:

Allergies:

____

Any conditions not mentioned above or alerts selected above that need further clarification, please
describe:____

____

Are you taking any **medications (prescription and non-prescription)** including regular doses of aspirin or birth control pills? If yes, please list below:

Medications *: ____

____

Have you taken or are you taking any **Bisphosphonate drug used to treat osteoporosis** or Paget's disease? Examples: Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, etc.
If yes, please list the drug and date taken:

Bisphosphonates: ____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery**:** ____

____

Physician name and phone number**:** ____

Preferred Pharmacy name and phone number**:** ______________________________________

By signing below, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

____

Patient Signature:

____

Patient Representative Signature:

____

Date:

Consent for services and financial policy

Most insurance plans are designed to pay for some, but not all of your dental treatment. Deductibles and other co-payments usually apply. We require payment of your portion of the fees at the time of service. We will do our best to accurately estimate your co-payment based upon the insurance information you provide to us. For your convenience, we accept cash, checks, debit cards, Visa/MC and Discover. A payment contract may be available to you through CareCredit upon credit approval.

We will file your insurance claims for you. We will also work closely with you and your insurance company to maximize the benefits to which you are entitled. Please remember, your insurance policy is an agreement between you and your insurance company. Any balance unpaid by your insurance company is your responsibility.

A service charge may be applied on any unpaid balance exceeding 60 days unless previously written financial arrangements are made.

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to the doctor and staff of Aloha Dental Group to telephone me to discuss this statement or my treatment.

I acknowledge that I am financially responsible for all charges. I hereby authorize the doctor to release information necessary to secure payment of benefits.

I authorize payment of the dental benefits otherwise payable to me directly to Aloha Dental Group, P.C..

Cancellation policy

We respectfully ask for scheduled appointments to be **cancelled at least two business days in advance**. (For example, cancelling a Monday appointment would need to occur no later than the previous Thursday.) We will enforce a policy of charging $50 for no-show appointments and those appointments not cancelled at least two business days in advance.

Patient Signature:

____

Patient Representative Signature:

____

Date: ____

HIPAA acknowledgement

I have received and reviewed a copy of Aloha Dental Group's privacy, security and breach notification policies and procedures (available at alohadentalgroup.com or in our office.)

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that I should ask the Privacy Official if I have any questions about these policies and procedures.

With whom may we leave information regarding your appointments: (name and phone number): ____

____

With whom may we leave information regarding your dental treatment: (name and phone number): ____

____

Consent for Internet Communications

I grant my permission to Aloha Dental Group, p.c. to upload and store confidential patient information (including account information, appointment information, and clinical information) to the secured website. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand that Aloha Dental Group, p.c. and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Aloha Dental Group, p.c. is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Aloha Dental Group, p.c. is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the website for Aloha Dental Group, p.c. with my ID and password. I also agree to immediately notify Aloha Dental Group, p.c. of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Aloha Dental Group, p.c. will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Aloha Dental Group, p.c. has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Aloha Dental Group, p.c. will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand that Aloha Dental Group, p.c. CANNOT and DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECEIVED USING THE SITE OR THE SERVICES.

Patient Signature:

____

Patient Representative Signature:

____

Date: ____