Maui Island Cozy Dental
110 E. Kaahumanu Ave., Suite 203
Kahului, HI 96732

Phone: 808-877-6233
Fax: 808-877-7898
www.mauiislandcozydental.com

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

NAME _____ SSN _____ BIRTHDATE _____
FIRST MI LAST

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

CHECK APPROPRIATE BOX: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

SPOUSE NAME _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

OCCUPATION: _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

IS THIS PERSON CURRENLTY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ SSN _____ RELATIONSHIP TO PATIENT _____

NAME OF EMPLOYER _____ BIRTHDATE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ POLICY/SUBSCRIBER ID # _____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

NAME OF EMPLOYER _____ BIRTHDATE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ POLICY/SUBSCRIBER ID # _____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE X _____ DATE _____

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MEDICAL INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

NAME _____ DATE _____

PERSONAL CARE PHYSICIAN (PCP) NAME: _____

PERSONAL CARE PHYSICIAN (PCP) ADDRESS: _____ CITY _____ STATE_____ ZIP_____

YES	NO		
☐	☐	1.	Have you had any major surgeries, or have been hospitalized within the last 5 years? If yes, for what? _____
☐	☐	2.	Have you ever been required to take any medications prior to any dental treatments? If yes, name of medication and for what? _____
☐	☐	3.	Are you currently being treated by a physician? If yes, for what? _____
☐	☐	4.	Are you currently taking any medications (this includes any over the counter vitamins and/or supplements)? If yes, name of medication(s) and for what? _____
☐	☐	5.	Are you allergic to any drugs? If yes, please list. _____
☐	☐	6.	Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
☐	☐	7.	Have you ever had a skin rash or other reaction to metal jewelry, or any other metals? If yes, what type of metal(s)? _____
☐	☐	8.	Do you smoke? If yes, what and how often? _____
☐	☐	9.	Do you bleed excessively upon injury? _____
☐	☐	10.	Are you pregnant? If yes, when is your due date? _____
☐	☐	11.	Have you ever been involved with any dental/medical legal activity? _____

MEDICAL CONDITIONS

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE:

A. HIV / AIDS	F. Epilepsy	K. High Blood Pressure	P. Rheumatic Fever
B. Arthritis	G. Glaucoma	L. Jaundice	Q. Sexually Transmitted Diseases
C. Asthma	H. Heart Murmur	M. Kidney Problems	R. Stroke
D. Cancer	I. Heart Problem **	N. Low Blood Pressure	S. Tuberculosis
E. Diabetes	J. Hepatitis	O. Nervous Breakdown or Psychiatric Therapy	T. Other Diseases **

** If you circled either I or T above, please describe the condition: _____

Please list any medications for any of the above conditions you circled? _____

EMERGENCY CONTACT

PERSON TO BE CONTACTED IN CASE OF AN EMERGENCY

Name: _____ Relationship to Patient: _____

Address: _____

Telephone: Home: _____ Cell: _____ Work: _____

SIGNATURE

_____ Date: _____

Reviewed By: _____ Date: _____

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DENTAL HISTORY

(PLEASE PRINT)

NAME _____ DATE _____

1. What is the purpose of your initial visit? _____
2. When your last dental visit, and what was done at that visit? _____
3. When was the last time your teeth were cleaned? _____
4. When was the last time your teeth had xrays taken? _____
5. Previous dentist's name _____
   a. Address: _____ Phone: _____

YES	NO	DON'T KNOW	
☐	☐	☐	6. Have you made regular dental visits?
☐	☐	☐	7. Have you lost any teeth or has any teeth been removed?
☐	☐	☐	8. Have the lost teeth been replaced? If yes, please circle what it has been replaced with: a. Fixed Bridge b. Removable Bridge c. Denture d. Implant
☐	☐	☐	9. Have you ever had any problems/complications with previous dental treatments? If yes, please explain: _____
☐	☐	☐	10. Do you clench or grind your teeth?
☐	☐	☐	11. Does your jaw click or pop?
☐	☐	☐	12. Have you experienced any pain or soreness in the muscles of your face or around your ear?
☐	☐	☐	13. Do you have frequent head, neck, or shoulder aches?
☐	☐	☐	14. Do you have teeth sensitivity? If yes, please circle one or more of the following that your teeth are sensitive to. a. Hot b. Cold c. Sweets d. Pressure
☐	☐	☐	15. Do your gums bleed or hurt?
			16. How often do you brush your teeth? _____ times per day.
☐	☐	☐	17. Do you floss your teeth? If yes, how often? _____
☐	☐	☐	18. Are any of your teeth loose, tipped, chipped, or has shifted?
☐	☐	☐	19. Have you ever had gum treatment or surgery? If yes: a. What type of treatment or surgery? _____ b. Where? _____ c. When? _____
☐	☐	☐	20. Have you had any orthodontic work done?
			21. How do you feel about your teeth in general? _____
☐	☐	☐	22. Do you have any questions or concerns? _____

By signing below, I certify that the above information is complete/accurate.

PATIENT/GUARDIAN SIGNATURE _____ DATE: _____

DENTIST'S SIGNATURE _____ DATE: _____

Maui Island Cozy Dental

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Office Policy Notice

Dear Patients,

Appointments you schedule at our office is a time reserved just for you. Any changes in these appointments affect many patients.

We certainly understand circumstances arise that prevent patients from keeping appointments. If you find it impossible to keep an appointment, we require you to give us at least 48 hour notice prior to your appointed time. We will try to give you a courtesy call but you are ultimately responsible for your appointments.

If you miss, cancel or change your appointment with less than 48 hour notice, you will be charged a cancellation fee of $45.00. This policy is in place out of respect for your dental team and our clients. Cancellations with less than 48 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

Thank you in advance for your cooperation

Sincerely,
Dr. Rongcal & Staff

Please sign below that you read and agree to these terms.

_____ Date: _____
Guardian / Patient signature

Comprehensive Treatment

- Adults * Children
- Exams * Extractions
- Root Canals * Crowns
- Bridges * Dentures * Partials
- Gum Problems * Fillings

Member: Academy of General Dentistry
Member: American Dental Association
Member: Hawaii Dental Association
Member: Maui County Dental Society

Restoring the Teeth's Natural Beauty

- Cleanings
- Bleaching
- Cosmetic Counseling
- White Fillings
- Porcelain Crowns
- Veneers

D.B.A. Maui Island Cozy Dental
Kahului, Hawai'i 96732

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of D.B.A. Maui Island Cozy Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

D.B.A. Maui Island Cozy Dental reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ YES	☐ NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (Parents, Grandchildren)	☐ YES	☐ NO
Other: _____	☐ YES	☐ NO
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ YES	☐ NO	Date Statement Provided: _____
Reason for not obtaining patient signature	☐	Needed more time to review Statement of Privacy Practices	
	☐	Wanted to consult another person before signing	
	☐	Physically unable to sign	
	☐	No reason offered	
	☐	Other:	