

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth
Legal Sex (Please CHECK ONE)* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose <small>*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.</small>				
Physical Address		City	State	Zip Code
Mailing Address		City	State	Zip Code
Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Day Phone <input type="checkbox"/> E-Mail Address				
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Do You Need An Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	
Housing Status: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Homeless: <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street, Beach, Etc. <input type="checkbox"/> Unreported <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional				
Ethnicity: <input type="checkbox"/> Chicano <input type="checkbox"/> Mexican American <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Not Reported <input type="checkbox"/> Mexican <input type="checkbox"/> Spanish (Or another Hispanic, Latino or Spanish Origin)		Farmer Status: <input type="checkbox"/> N/A <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal Active Military or Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race (CHECK ONE below that best describes you): <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Fijian <input type="checkbox"/> Chuukese <input type="checkbox"/> Filipino <input type="checkbox"/> Portuguese <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Marshallese <input type="checkbox"/> I-Kiribati <input type="checkbox"/> Chinese <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Micronesian <input type="checkbox"/> Kosraean <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Tahitian <input type="checkbox"/> Palauan <input type="checkbox"/> Yapese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Native American <input type="checkbox"/> Tongan <input type="checkbox"/> Pohnpeian <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> All Other (Please specify): _____				
Employer/School Name:		<input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Full-Time <input type="checkbox"/> Casual <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired		
Occupation:		Family Size (includes self, spouse, & children under 18): _____	Family Income: <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$ _____	

PARENT/LEGAL GUARDIAN or GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____				
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Mailing Address		City	State	Zip Code
Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Day Phone <input type="checkbox"/> Email Address				
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Do You Need An Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	
Employer Name:		<input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Full-Time <input type="checkbox"/> Casual <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired		
Occupation:		Family Size (includes self, spouse, & children under 18): _____	Family Income: <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$ _____	

Patient Registration

Patient Name: _____

MRN: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:		Relationship:
Home Phone	Work Phone	Cell Phone

PATIENT PORTAL

Patient Portal is WHC's latest technology that allows you to schedule and view appointments, request medication refills, see lab results, communicate with your health care team, ask questions about your bill, and request your health record.

Are you enrolled into Patient Portal? ☐ Yes ☐ No **If No, do you need assistance to enroll?** ☐ Yes ☐ No

ADVANCE DIRECTIVES

Do you have an Advance Directive? (Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond) ☐ Yes ☐ No

MARKETING & PROMOTIONS

How did you hear about us? (Check all that apply)	<input type="checkbox"/> Family/Friends	<input type="checkbox"/> Mailer	<input type="checkbox"/> Web Search	<input type="checkbox"/> Banner
	<input type="checkbox"/> Social Media	<input type="checkbox"/> Print Ads	<input type="checkbox"/> Other (Please specify): _____	
How do you want to stay updated on services and classes? (Check all that apply)	<input type="checkbox"/> Email	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Patient Portal	
	<input type="checkbox"/> Text Message	<input type="checkbox"/> Mailer	<input type="checkbox"/> Other (Please specify): _____	

Initials I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or organization to process claims on my behalf. I authorize payment of benefits to WHC for services rendered.

Initials I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Initials I authorize WHC to communicate via text, email, and phone call. Message & Data rates may apply. If I am not available, I give WHC consent to communicate a message which will identify the WHC service(s) and/or the date and time of my appointment(s). I may opt out at any time and will need to notify the Front Office.

Initials **MINOR:** I consent and authorize Waimānalo Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

Initials Patient was informed of [Waimānalo Health Center's Rights & Responsibilities](#). Information is available on WHC's website and patient may request a hard copy at any time.

Initials Patient was informed of [Waimānalo Health Center's Notice of Privacy Practices](#). Information is available on WHC's website and patient may request a hard copy at any time.

Patient or Legal Guardian's Signature

Date Signed

Guarantor's Signature

Date Signed

FOR OFFICE USE ONLY

Record # _____			
Pt Status Type:	<input type="checkbox"/> Inactive <input type="checkbox"/> Scheduled <input type="checkbox"/> Active	Valid ID:	<input type="checkbox"/> Scan ID <input type="checkbox"/> Update NG Pt Picture
	<input type="checkbox"/> Non-WHC Active <input type="checkbox"/> Dental Patient Only	Insurance:	<input type="checkbox"/> Scan Card <input type="checkbox"/> Update Info/Card
Collected By: _____		Entered By: _____	
Date: _____		Date: _____	

Patient Registration: INSURANCE

Patient Name: _____

MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION									
Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
Plan Name		Policy # / Subscriber #		Group #		Effective Date:		Expiration Date:	
Home Address				City		State		Zip Code	
Home Phone			Work Phone			Cell Phone			
SECONDARY MEDICAL INSURANCE INFORMATION									
Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
Plan Name		Policy # / Subscriber #		Group #		Effective Date:		Expiration Date:	
Home Address				City		State		Zip Code	
Home Phone			Work Phone			Cell Phone			
PRIMARY DENTAL INSURANCE INFORMATION									
Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
Plan Name		Policy # / Subscriber #		Group #		Effective Date:		Expiration Date:	
Home Address				City		State		Zip Code	
Home Phone			Work Phone			Cell Phone			
SECONDARY DENTAL INSURANCE INFORMATION									
Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____									
Policy Holder Name				Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female			
Plan Name		Policy # / Subscriber #		Group #		Effective Date:		Expiration Date:	
Home Address				City		State		Zip Code	
Home Phone			Work Phone			Cell Phone			

I, _____, the undersigned, hereby give Waimānalo Health Center to examine my (son/daughter/ward):

Child's Name

Date of Birth

to make such tests as are necessary for his/her diagnosis and care, and to give such treatment as the Waimānalo Health Center physicians deem necessary. This includes diagnosis and care at the Center clinic, at laboratories, X-ray facilities, clinics, emergency rooms and offices of specialists, and psychological tests.

I understand that for major surgery or other major procedures, special explanations will be made to me, and special permission will be requested for me, unless the emergency is too great to wait to contact me.

WHC will inform the parent/legal guardian before starting or making any change the minor patient's medications without first speaking to a parent/legal guardian.

This consent which I am signing is for the ongoing health care of my (son/daughter/ward) until I withdraw him/her from the Center. I understand that it includes consent for general tests, tuberculin tests, applications to skin or mucous membranes, examination of mouth, genitals, rectum, and ears, repair of small cuts, and all other ordinary medical office procedures. I am not hereby consenting to any experimental procedures nor to tests for research or scientific study.

I certify that I have read (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

Parent/Legal Guardian Signature

Date

I authorize and consent to any examinations, x-rays, anesthetic, medical diagnosis, immunization, or treatment rendered by the Waimānalo Health Center in the event that my child(ren) is brought to the Center by the following persons:

(Name)

(Relationship)

(Name)

(Relationship)

(Name)

(Relationship)

(Name)

(Relationship)

(Signature of Parent or Legal Guardian)

(Date)



APPOINTMENT KEEPING AGREEMENT

Patient Information

It is important to keep your medical appointment(s) and to be on time. At Waimānalo Health Center (WHC), our goal is to provide quality medical care in a timely manner. In our efforts to make your visit more comfortable and to minimize your wait time, we have updated and implemented the following policies and procedures.

A. Check-in Policy:

To ensure access and timeliness of medical care, the front office and medical team will inform you to arrive at your designated check-in time, to allow for registration and screening prior to your scheduled appointment time. You are encouraged to:

1. Call by 3:00 PM on the day prior to your appointment to notify us of any changes; and/or
2. If you may be late for your designated check-in time.

B. Late Arrival Policy

We understand that delays can occur, however, it is important to us to see all patients as timely as possible. Not arriving at your designated check-in time is considered late. Clock times on the WHC Front Desk computers will be used to validate ALL designated check-in times. If you arrive late for your appointment, you may experience one of the following:

1. You may be asked to wait until the provider is available.
2. You may be asked to reschedule your appointment for a later time on the same day or on a different day.
3. You may be offered an appointment with another provider on the same day, if available.
4. If no open appointments are available, you may choose to wait in case an opening arises – thought this is not guaranteed.
5. Kukui Clinic (Behavioral Health) Only: If you arrive late, you will be seen for the remainder of your scheduled appointment time.

C. Cancellation Policy

If you are not able to make your scheduled appointment, please call us at (808) 259-7948 by 3:00 PM on the day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 PM on Friday. Appointments are in high demand, and your early cancellation will give another person access to timely medical care.

1. If you are not able to speak to someone, please leave a message with your name, phone number, your appointment date/time and request for rescheduling or cancellation reason.
2. If you receive appointment text reminders, you may reply with an "X" to cancel your appointment.

D. No Show Policy:

All patients who miss three (3) appointments dates in a three-month period, will be considered a chronic no show. After the third missed appointment date, you will be placed on a "Same Day Only" status. You may return to a regular status at the end of the rolling three-month period.

Waimānalo Health Center is committed to providing exceptional care. Your help in keeping your appointments enables us to provide better and timelier care for you and all of our patients.

I have read and consent to these terms.

Print Patient Name

Print Legal Guardian Name

Relationship

Patient Signature
(Parent/Legal Guardian if under 18)

Date

Child Health/Dental History Form

ADA American Dental Association®

America's leading advocate for oral health

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth																																				
Parent's/Guardian's Name			Relationship to Patient																																					
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>																																								
Phone <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>																																					
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.																																								
Has the child had any history of, or conditions related to, any of the following: <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> HIV +/-AIDS</td> <td><input type="checkbox"/> Mononucleosis</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Immunizations</td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/> Tobacco/Drug Use</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> Growth Problems</td> <td><input type="checkbox"/> Kidney</td> <td><input type="checkbox"/> Pregnancy (teens)</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Bladder</td> <td><input type="checkbox"/> Chronic Sinusitis</td> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Latex allergy</td> <td><input type="checkbox"/> Rheumatic fever</td> <td><input type="checkbox"/> Venereal Disease</td> </tr> <tr> <td><input type="checkbox"/> Bleeding disorders</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Liver</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Bones/Joints</td> <td><input type="checkbox"/> Ear Aches</td> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Measles</td> <td><input type="checkbox"/> Sickle cell</td> <td></td> </tr> </table>					<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____	<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid																																			
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<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell																																				
Please list the name and phone number of the child's physician: Name of Physician _____ Phone _____																																								

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements?	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities?	27. <input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by _____
 Date _____