

Please print clearly & fill-out form completely 9/12

QMC Dental Clinic Patient Information

Personal Information	Last Name		First Name		Middle Initial	Preferred Name / other names		<input type="checkbox"/> Male	<input type="checkbox"/> Female
	Age in yrs	Date of Birth		<input type="checkbox"/> U.S Citizen <input type="checkbox"/> Resident Alien <input type="checkbox"/> Not U.S. citizen		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
	Home address		Street		City	State	Zip		
	Mailing address		Street		City	State	Zip		
	Social security number		Best phone number		Cell or alternate phone		Email address		

Employer Info.	Occupation	Employer / If a STUDENT, what school does patient attend?					<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time
	Work address	Street		City	State	Zip		

Emergency Contact	Notify in Emergency	Last Name	First Name	Middle Initial	Relationship to patient		
	Mailing address	Street		City	State	Zip	
	Best phone number		Cell or alternate phone number				

Does the patient need: Interpreter: What language? _____ Other accommodation (specify): _____

Race & Ethnicity

What (single) RACE do you most identify with: Asian Black White Native Hawaiian Native American Other

Are you Hispanic or Latino? Yes No Don't know

What (single) ETHNIC group does the patient most identify with: _____

Payer Info.	Last Name		First Name		Middle Initial	Relationship to patient		
	Mailing address		Street		City	State	Zip	
	Best phone number		Cell or alternate phone		Social Security Number		Date of birth of payer	
	Name of Employer				Payer's Occupation			
	Employer's address		Street		City	State	Zip	

Insurance	Primary Health Plan			
	Dental Plan:	Subscriber	ID #	Group
	Medical Plan:	Subscriber	ID #	Group
	Secondary Health Plan			
Dental Plan:	Subscriber	ID #	Group	
Medical Plan:	Subscriber	ID #	Group	

If patient a minor or disabled	Patient resides with: <input type="checkbox"/> Parent(s) <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Care home Caregiver <input type="checkbox"/> Other: _____		
	Address		
	Best phone number	Alternate phone number	
	Relationship to patient:		
	Address		
	Best phone number	Alternate phone number	

★ Information provided by: _____ Signature: _____ Date: _____

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- 1 Patient Name: _____ Preferred Name: _____ Date: _____
- 2 Date of Birth: _____ Age (yrs): _____ Best phone number: _____
- 3 Primary Care Physician: _____ Location: _____ Phone: _____
- 4 Other doctors now seeing: _____ Location: _____ Phone: _____
- 5 Person filing out form: Same or _____ Relationship to patient: _____

		<i>Answer all by checking a box</i>	Yes	No	Don't Know	Notes
6	HAS PATIENT EVER BEEN HOSPITALIZED?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7	If Yes, why and when?					
8	DOES THE PATIENT HAVE A DISABILITY?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9	If Yes, what is diagnosis?					
10	IS THE PATIENT TAKING ANY MEDICATIONS?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11	List all medications:					
12	ANY ALLERGIES?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13	Local anesthetics		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14	Latex		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15	Aspirin, Tylenol or Motrin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16	Penicillin or other antibiotics		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17	Other medicines? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18	Food (specify) _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19	Other (specify) _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20	DENTAL PROBLEMS TODAY?					
21	Healthy, no problems I know of		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22	Dental pain now which?: mild - moderate - severe - extreme		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23	Loose teeth		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24	Problems with my gums		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25	I think a dental infection		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26	Pain that wakes during the night		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27	A foul smell and/or taste		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28	Swelling or pain other than teeth: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29	MEDICAL HISTORY					
30	Are you in good health?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31	Has there been any change in your health within the past year?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32	Currently under the care of a physician?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33	If yes, what problems?					
34	History of problems with alcohol or drug?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35	Women: Are you pregnant?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36	Women: Are you presently taking birth control pills?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

37 HAS PATIENT EVER HAD?	Yes	No	Don't Know	Notes
38 Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39 Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40 Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41 Immune system problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
42 Jaw or other joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
43 Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
44 Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45 Lung (breathing) problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
46 Mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47 Neurological problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48 Stomach or intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49 Allergic reaction to anything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50 Arteriosclerosis (blocked heart arteries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52 Blood pressure HIGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
53 Blood pressure LOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
54 Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
55 Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
56 Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
57 Dementia (Alzheimer's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
58 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59 Dry mouth / reduced saliva production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
60 Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
61 Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
62 Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
63 Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
64 HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
65 Hormone replacement therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
66 Hyperbaric oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
67 Joint replacement surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
68 Kidney dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69 Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
70 Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
71 Persistent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
72 Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
73 Recent unexplained weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
74 Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
75 Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
76 Lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
77 Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
78 Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Doctor's notes, sign & date:

Doctor's notes, sign & date:

Doctor's notes, sign & date:

QMC DENTAL CLINIC - GENERAL INFORMATION & INFORMATION SHARING AUTHORIZATION

HOURS OF OPERATION The QMC Dental Clinic is open Mon-Thurs 8am-4pm and Fri 9am-4pm and may be closed on some holidays. We may be contacted at 691-4292 or by fax at 691-5028.

APPOINTMENT RESCHEDULING ►The QMC Dental Clinic supports many services throughout the Medical Center, including the Emergency Department. ►On occasion it may be necessary to reschedule out-patient dental appointments with short notice in order to respond to serious patient emergencies and other responsibilities. ►We value all of our patients. If this is a problem, we advise patients that they may wish to consider the option of seeking dental care from a private practice dentist or community health center; rather than at our hospital-based dental office.

MUTUAL RESPECT ►We commit to do our best to be on-time and expect our patients to arrive to all dental appointments on time. If you are late, we may not be able to see you that day and the event may be considered a missed appointment. ►Patients who miss 3 or more appointments will be dismissed. ►Please be sure to give us at least 24 hours notice if your appointment needs to be canceled. ►Patients who are disruptive or disrespectful to clinic staff and/or other patients will be dismissed.

WHAT TREATMENT DO I NEED? ►If you were referred to us by another dentist, QMC Dental Clinic’s treatment plans are dependent upon our own diagnostic examination and radiographic imaging (as determined necessary). ►Prior to proceeding with dental treatment services, a treatment plan will be developed with cost estimates which will be reviewed with you. ►Changes in the treatment plan will be discussed with you and be made with your understanding and agreement. ►We will make every effort to explain our treatment plans. If ever any question, please feel free to ask. ►We will not perform dental services requested that we feel are not in a patient's best interest.

WHAT'S COVERED? ►We are participating providers for Hawaii Dental Service (HDS), Hawaii Medical Service Association (HMSA) and Medicaid/QUEST (HDS). ►All dental (insurance) plans vary on what services they cover and the proportion of covered services they will reimburse on your behalf. For many services the coverage is not 100 percent and the patient is responsible for a co-payment. This balance will be collected on the day of service delivery unless other prior arrangements are made.

MEDICARE Does not cover any dental services, including diagnostic services.

MEDICAID ►Medicaid dental coverage (QUEST and HDS-Medicaid) for individuals 21 years of age and older is limited to emergency dental services. Those 'emergency dental services' are a limited, problem focused examination and dental surgery for the management of dental pain and/or infection. ►Coverage for adults does not pay for the routine examinations, teeth cleaning, new or replacement dental fillings, repair of dentures, re- cementation of loose caps or other basic dental treatment services. Uncovered services will be charged directly to the patient. ►QMC Dental Clinic does not have provider agreements with Medicaid programs in other States. Payment in full is required at the time of service delivery if covered by Medicaid from another state.

PAPER WORK ►In cases requiring pre-authorization of dental services from your dental plan prior to performing some treatment services. The QMC Dental Clinic will submit the necessary authorization requests to your dental plan and treatment appointments will be scheduled pending the pre-authorization of payment. ►While QMC Dental Clinic will assist you by providing timely and accurate information to your dental plan, any disputes that may arise associated with dental plan coverage limitations are between the patient and their dental plan.

METHODS OF PAYMENT ►Payments may be made at the reception desk with credit card, cash and personal check. ►Dentures and dental crowns must be paid for before the procedure will be started.

INFECTION PREVENTION & CONTROL ►The safety of our patients and staff is our highest priority. The QMC Dental Clinic follows the strictest of protocols associated with disinfection, sterilization and patient safety. Feel free to ask if you have any concerns or questions regarding the precautions we employ for patient and staff safety. (req. CODA)

Additional information is provided through documents attached here: 1) CONSENT TO TREATMENT AND TERMS AND CONDITIONS OF SERVICE and 2) PATIENT RIGHTS & RESPONSIBILITIES

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS & APPROVAL TO LEAVE MESSAGES
Initial each if you agree

- ★ I authorize the dentists and QMC Dental Clinic staff to release information required to secure the payment of benefits and to share information with my medical doctor(s) determined to be important for my health management.
- ★ I authorize payment directly to The Queen's Medical Center of all health plan (insurance) benefits payable on my behalf for services rendered.
- ★ I understand that I (the patient or guardian) am responsible for any outstanding account balances due subsequent to the processing of dental claims submitted on my behalf.
- ★ I authorize QMC Dental Clinic staff to leave messages at the phone numbers I've shared and/or to mail postcards to my mailing address relating to dental appointment reminders and confirmation.

★ _____
Patient Signature (or patient's representative)

Date

QMC Representative

Date