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	❑ Male ☐ Female
Age in yrs	Date of Birth	❑ U.S Citizen ☐ Resident Alien ☐ Not U.S. citizen	❑ Single ☐ Married ☐ Widowed ☐ 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?	❑ Full-time ☐ 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 to 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 Secutiry 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: ☐ Parent(s) ☐ Legal Guardian ☐ Care home Caregiver ☐ Other: _____

Primary Caregiver:	Address	
Relationship to patient:	Best phone number	Alternate phone number
Legal Guardian:	Address	
Relationship to patient:	Best phone number	Alternate phone number

★

Information provided by:_____ **Signature:**_____ **Date:** _____

Please print clearly & fill-out form completely

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:

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

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

Doctor's notes, sign & date:

Doctor's notes, sign & date:

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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.

MEDI*CARE* Does not cover any dental services, including diagnostic services.

MEDI*CAID* ►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*

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