ABOUT YOU

First Name: _____ MI:_____ Last Name: _____

I prefer to be called: _____

Birthdate: _____ Age: _____ SSN: _____

Address: _____ Apt #: _____ City/State: _____

Home phone: _____ Cell phone:_____ Work phone: _____

E-mail address: _____

Employer: _____

Work address: _____

Referred by: _____

SIGNIFICANT OTHER

First Name: _____ MI: _____ Last Name: _____

Birth date: _____ Age: _____ SSN: _____.

Home phone: _____ Cell phone: _____ Work phone: _____

Employer:_____

WHO SHOULD WE CONTACT IN AN EMERGENCY?

First Name: _____ Last Name: _____

Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

DENTAL INSURANCE

Primary Insurance name:_____ Primary subscriber ID: _____ Grp #: _____

Subscriber's name:_____ D.O.B._____ SSN: _____

Relation to subscriber: _____

Secondary Insurance name: _____ Secondary subscriber ID: _____ Grp #: _____

Subscriber's name: _____ D.O.B. _____ SSN: _____

Relation to subscriber: _____

YOUR MEDICAL CARE

Do you have a personal physician? Yes _____ No ____ Date of your last visit: _____

Physician's name: _____ Physician's phone: _____

Are you currently under the care of a physician? If yes, please explain: _____

_____

HEALTH INFORMATION

Your current physical health is: Good ____ Fair _____ Poor _____

Do you require antibiotics before dental treatment? Yes _____ No _____

Have you ever taken Fosamax, Actonel, Boniva, or any other Bisphosphonate? Yes ____ No ____

If yes, list each one: _____

Do you smoke or use tobacco? Yes _____ No _____

Do you use controlled substances? Yes _____ No _____

DENTAL CARE

Previous dentist: _____ Last visit date: _____

Why have you come to the dentist today? _____

_____

Have you ever had a serious or difficult problem associated with previous dental work? Yes _____ No _____

Are you currently in pain? Yes _____ No _____ Do your gums ever bleed? Yes _____ No _____

Have you ever had pain or discomfort in your jaw? Yes _____ No _____

How often do you brush? _____

How often do you floss? _____

Your current dental health is: Good _____ Fair _____ Poor _____

FOR WOMEN

Are you using a prescribed birth control method? Yes _____ No _____

Are you pregnant? Yes _____ No _____ Are you nursing? Yes ____ No _____

SLEEP

Do you snore while you sleep? Yes _____ No _____

Have you been diagnosed/treated for sleep apnea? Yes _____ No _____

Do you use a CPAP or other appliance? Yes _____ No _____

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ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (CHECK ALL THE APPLY)

_____ Aspirin
_____ Codeine
_____ Dental Anesthetics
_____ Erythromycin
_____ Latex
_____ Metals
_____ Penicillin
_____ Tetracycline

List any other drugs or materials that you are allergic to: _____.

HAVE YOU EVER HAD THE FOLLOWING? (CHECK ALL THAT APPLY)

_____ Abnormal Bleeding
_____ Alcohol/Drug Abuse
_____ Anemia
_____ Arthritis
_____ Artificial Bones, Joints, Valves
_____ Asthma
_____ Cancer, Chemotherapy
_____ Congenital Heart Defect
_____ Diabetes
_____ Difficulty Breathing
_____ Emphysema
_____ Epilepsy
_____ Fainting Spells
_____ Frequent Headaches
_____ Glaucoma
_____ Heart Attack
_____ Heart Murmur
_____ Heart Surgery
_____ Hepatitis/Type _____
_____ Herpes, Fever Blisters
_____ HIV, AIDS
_____ High Blood Pressure
_____ Hospitalized for Any Reason
_____ Jaundice
_____ Kidney Problems
_____ Liver Disease
_____ Mitral Valve Prolapse
_____ Osteoporosis
_____ Pacemaker
_____ Psychiatric Problems
_____ Radiation Treatment
_____ Respiratory Disease
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Slow healing wounds
_____ Stroke
_____ Thyroid problems
_____ Tonsillitis
_____ Tuberculosis
_____ Ulcer
_____ Venereal Disease

<u>MEDICATION LIST (PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING</u>):

RX NAME	DOSAGE	WHAT IS IT TAKEN FOR

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	CHANGES TO YOUR HEALTH	PATIENT SIGNATURE	DENTIST INT

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

PATIENT CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Parent Signature: _____ Date: _____

Dental Staff Initial: _____ Dentist Initial:_____

FINANCIAL POLICY

The office of Dr. Michael M. Okano is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **DR. MICHAEL M. OKANO PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adults patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to any one of our payment options noted above.

INSURANCE

Dr. Michael M. Okano provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient may not rely upon any information provided by Dr. Michael M. Okano's staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Dr. Michael M. Okano. However, if you are paid by the insurance company instead of Dr. Michael M. Okano, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance company, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 12% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $45.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge $75.00 for missed appointments. Please help us service you better by keeping scheduled appointments.

Thank you for your understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Patient/Parent Signature: _____ Date: _____

Dental Staff Initial: _____ Dentist Initial: _____

Notice of privacy practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice of our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and the new notice will be available upon request. You may request a copy of this notice at any time.

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing you to treatment.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, verification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

FAMILY AND FRIENDS: We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose your health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our personal professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and out experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

PUBLIC HEALTH: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

APPOINTMENTS: We may use your information to provide appointment reminders or information about treatment alternatives or other dental-related benefits and services that may be of interest to you.

RESEARCH: Your health information may be used or disclosed for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has the approved research.

DECEDENTS: Health information may be used or disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

WORKERS COMPENSATION: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

REQURIED BY LAW: We may disclose your health information when we are required by law to do so.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

COMPLAINTS: You may submit complaints to your dentist, your insurance carrier and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

MY RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Print name of Patient/Parent: _____

Patient/Parent Signature: _____ **Date:** _____