# PERIODONTICS HAWAII
# Aaron J. Colby, DDS, MS

"WELCOME TO OUR PRACTICE"

**PATIENT INFORMATION**

Name _____ Phone# _____ Cell/Pager #_____
Last First MI
Social Security Number ____ -____ - ____ Age ____Birthdate _____E-mail Add._____

Patient Address _____
Sex ( ) M ( ) F ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced
Patient Employed by _____ Occupation_____
Business Address _____ Business Phone #_____
If Patient is a Student, Name of School/College _____
Spouse's Name _____ Occupation _____ Business # _____
Spouse's Business Address _____
Whom May We Thank for referring you? _____
Person to Contact in Case of Emergency _____Phone# _____Relationship_____

**INSURANCE INFORMATION**
Who is responsible for this account? _____ Relationship_____
Social Security _____ DOB _____

Insurance Company _____
Subscriber Name _____ Subscriber # _____ Subscriber's Birth date _____
Is patient covered by other insurance? ( ) Yes ( ) No
Subscriber Name _____ Birthdate _____ SS# _____
Relationship to the Patient _____
Insurance Company _____ Subscriber # _____ Contact # _____ Group # _____

**AUTHORIZATION**
I hereby grant permission to the dentist to perform all procedures and diagnostic tests which he/she deems necessary. These accepted procedures may include x-rays, pictures (which might be used for marketing and/or for our gallery), administration of medications, local anesthetics(complications in rare cases might be prolonged numbness which sometimes might be indefinite), dental prophylaxis, fluoride treatment, dental restorations, root canal treatment & dental surgical procedures. If patient is a minor, I, as a parent/legal guardian, understand that it is necessary for me to be present while my child is under treatment. I give consent to the dentist to perform any necessary dental treatment to my child whether I am present or not in the clinic.

**Patient Signature** _____**Date** _____
**Parent or Guardian if Minor** _____ **Relationship** _____**Date** _____

**ASSIGNMENT CONSENT AND RELEASE**
I authorize my insurance company to pay Dr. Aaron Colby all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payments of benefits. **I understand that I am financially responsible for all charges whether or not covered by insurance.** If a collection agency services are required, I further agree to pay all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you.
I understand that there will be a $25.00 fee for a returned check.
If I become delinquent in my account, I authorize this office to send me to *Guardian Capital Collection Agency* with a $25.00 processing fee.
I have read, understand, and been offered a copy of the office policy for privacy practices (HIPAA).
I authorize Periodontics Hawaii to leave message(s) on my voicemail/answering machine to confirm my appointment.

**Signature** _____ **Date**_____

# PERIODONTICS HAWAII

**We take pride in the care we give to our patients , and this becomes possible when we know more about you.**

What's most important to you in the DENTAL CARE YOU RECEIVE?_____
What needs to happen while you're here to achieve this CARE? _____
Why did you leave your last Dentist?_____
What else would you like to share with the doctor about your care/and or needs? _____

Y N Do you like your smile?
Y N If we could show you an easy and safe way to lighten your teeth, would you be interested?
Y N Today's dentistry has made great advances, we can instantly straighten your teeth over a two week time period. Does it interest you at all?
Y N Do you have pain in any teeth currently?
Y N Do you have jaw (TMJ) pain?
Y N Do you have headaches, neck pain, back pain, ringing in the ears, tingling in your hands?

**MEDICAL HISTORY**

Medical Doctor's name _____ Phone # _____

| | | |
|---|---|---|
| Are you under a doctor's care now? Why? _____ | YES | NO |
| Have you been hospitalized for the past two years? Why? _____ | YES | NO |
| Are you taking any medications, pills, or drugs? What? _____ | YES | NO |
| Are you taking FOSAMAX, ACTONEL, BONIVA ? _____ | YES | NO |
| Are you allergic to any medications or substance? What? _____ | YES | NO |
| Have you ever taken Phen-Fen or Redux? _____ | YES | NO |
| Do you have any form of Implants? If yes, please describe _____ | YES | NO |
| WOMEN - Are you or could you be pregnant? If yes, how many months _____ | YES | NO |

**PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:**

| | | | |
|---|---|---|---|
| ( ) Heart Disease | ( ) Chest Pain | ( ) Hepatitis A (Infection) | ( ) Chemotherapy/ Radiation |
| ( ) High Blood Pressure | ( ) Stroke | ( ) Hepatitis B | ( ) Thyroid Disease/Problem |
| ( ) Low Blood Pressure | ( ) Swelling of feet/Ankles | ( ) Liver Disease | ( ) Stomach Problem/Ulcer |
| ( ) Congenital Heart Lesion | ( ) Fainting or Dizziness | ( ) High Cholesterol | ( ) Parathyroid Disease |
| ( ) Artificial Heart Valve | ( ) Snoring | ( ) Sinus Trouble | ( ) Blood Transfusion |
| ( ) Heart Pacemaker | ( ) Emphysema | ( ) Abnormal Bleeding | ( ) Drug Addiction |
| ( ) Heart Surgery | ( ) Gout | ( ) Frequent Cough | ( ) Venereal Disease |
| ( ) Heart Murmur | ( ) Diabetes | ( ) Lung Disease | ( ) Herpes |
| ( ) Anemia | ( ) Kidney Trouble | ( ) Tuberculosis | ( ) HIV/AIDS |
| ( ) Arthritis | ( ) Asthma | ( ) Rheumatism | ( ) Cosmetic Surgery |
| ( ) Blood Disease | ( ) Glaucoma | ( ) Epilepsy or Seizures | ( ) Artificial Joints |
| ( ) Cancer | ( ) Psychiatric Care | ( ) Allergies | ( ) Rheumatic Fever |

Have you ever had any serious illness not checked above? _____ YES NO
Please describe in detail _____

***PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. 48 HOURS (EXCLUDING SUNDAYS AND HOLIDAYS) NOTICE MUST BE GIVEN FOR ALL APPOINTMENT CANCELLATIONS OR YOU WILL BE CHARGED A $50.00 FEE PER RESERVED HOUR.***

**PATIENT SIGNATURE** _____ **Date** _____

**(PARENT OR GUARDIAN, IF MINOR)** _____ **Date** _____

**Reviewed By: Dr.** _____ **Date** _____