OAHU ENDODONTICS, INC.

KIMO M. CHUN, D.D.S.

PATIENT INFORMATION

Patient Name: ______________________________

Last First MI (Preferred Name)

Birth Date: ______/______/______ Marital Status (please circle): married single child other

Social Security # ____-____-____ Driver's License # ______________

Phone (Home): ______________(Work): ______________(Cell): ______________

Mailing Address: ______________________________

Street Apt No.

____

City State Zip Code

Physical Address: ______________________________

☐ Check if same

Street Apt. No.

____

City State Zip Code

Email Address: ______________@______________

HEALTH INFORMATION Have you ever had any of the following? Please check those that apply:

- ☐ Allergy: Penicillin
- ☐ Allergy: Codeine
- ☐ Allergy: Local Anesthetic
- ☐ Allergy: Latex
- ☐ Allergy: ______________
- ☐ Allergy: ______________
- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Bruise Easily
- ☐ Glaucoma
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pregnancy
  Due date: ______________
- ☐ Nursing
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other:
  ____
- ☐ ______________
- ☐ ______________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ______________________________

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: ______________________________

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ______________________________

Are you taking any medications? ☐ Yes ☐ No

If yes, please list: ______________________________

Name of Physician: ______________________________ Phone: ______________

Do you have any health problems that need further clarification?

If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform you at the next appointment without fail.

______________________________ Date: ______________

Signature of patient, parent or guardian

Name of office referring you to our practice: ______________________________

Patient Name:

FINANCIAL INFORMATION (RESPONSIBLE PARTY)

☐ Check box if same as patient and skip this section, or

Name: ______________________________

☐ Male ☐ Female

Relationship to patient: ☐ Spouse ☐ Other: ______________________________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ____________________ (Work): ____________________ (Cell): ____________________

Address: ______________________________

Street Apt. No.

____

City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________________

Address: ______________________________

Street City State Zip Code Phone No.

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ____________________ Subscriber ID #: ____________________ Group #: ____________________

Insured's Employer Name: ______________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________________________

Insurance Plan Name and Address: ______________________________

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SECONDARY INSURANCE

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ____________________ Subscriber ID #: ____________________ Group #: ____________________

Insured's Employer Name: ______________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________________________

Insurance Plan Name and Address: ______________________________

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AUTHORIZATION AND RELEASE

I authorize Dr. Kimo M. Chun to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

TREATMENT FEE

We require payment of your estimated patient share when services are rendered. Patients with insurance are to pay their estimated portion when treatment is started. Any remaining balance not covered by insurance is due within 10 days after receipt of our billing statement. If payment from the insurance company is not received within 30 days of completion of the dental treatment, the account balance will be due from you.

In the event payments are not received by agreed-upon dates, I understand that a 1 ½% finance charge may be added to the balance of my account.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ____________________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ____________________

Signature of guarantor of payment/responsible party

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Oahu Endodontics, Inc.
Kimo M. Chun, D.D.S.

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature: ____

Date:____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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