SUNSHINE DENTAL CENTER, LLC

94-748 D HIKIMOE STREET WAIPAHU HI 96797 | PHONE: (808) 677-3751 | FAX: (808) 678-8646
1437 NORTH KING STREET HONOLULU HI 96817 | PHONE: (808) 847-4868 | FAX: (808) 841-9708

REGISTRATION / HEALTH HISTORY / CONSENT FORM

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION ON THE PATIENT RECEIVING DENTAL TREATMENT

TODAY'S DATE _____ NAME _____ BIRTHDATE _____

SOCIAL SECURITY NO. _____-_____-_____ PHONE # _____CELL # _____ ( ) MALE ( ) FEMALE

ADDRESS _____
STREET CITY STATE ZIPCODE

EMPLOYER _____ OCCUPATION _____ WORK # _____

EMAIL _____ ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED ( ) SEPARATED

SPOUSE NAME _____SPOUSE BIRTHDATE _____ SPOUSE SSN _____
PERSON RESPONSIBLE FOR THE ACCOUNT (IF NOT THE PATIENT) _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL & GRADE / COLLEGE _____

GUARANTOR INFORMATION ***(FOR PATIENTS UNDER AGE 18 OR PATIENTS UNDER THE CARE OF ANOTHER INDIVIDUAL)***

GUARANTOR NAME _____BIRTHDATE_____ SSN _____

ADDRESS _____RELATIONSHIP TO PATIENT _____ PHONE # _____

EMPLOYER & ADDRESS _____ WORK # _____

INSURANCE INFORMATION

PRIMARY INS. COMPANY: _____ SUBSCRIBER NAME _____ MEMBER ID_____
SECONDARY INS. COMPANY: _____ SUBSCRIBER NAME _____ MEMBER ID_____

HEALTH HISTORY / MEDICAL INFORMATION

1. Do you currently have symptoms of fever, cough, or shortness of breath? ___YES ___NO If yes, when did it start? _____
2. Have you traveled within the past month (outer island/out-of-state/out-of-country)? ___YES ___NO If yes, where? _____
3. Are you having pain or discomfort at this time? ___YES ___ NO
4. Have you been a patient in the hospital during the past two years? ___YES ___ NO
5. Have you been under the care of a medical doctor during the past two years? ___YES ___ NO
6. **Primary Care Physician** _____ Address _____Phone _____
7. When you are walking up the stairs, do you experience chest pain, shortness of breath or fatigue? ___YES ___NO
8. Are you pregnant? ___ YES ___ NO; If yes, due date? _____; Are you taking birth control? ___YES ___NO
9. Are you allergic or have you reacted adversely to any of the following? ***Initial for No Known Drug Allergies:*** _____
   ( ) Aspirin ( ) Local Anesthetic ( ) Penicillin ( ) Tetracycline ( ) Erythromycin ( ) Amoxicillin ( ) Latex ( ) Lidocaine
   ( ) Epinephrine ( ) Nitrous Oxide ( ) Valium ( ) Darvon ( ) Codeine ( ) Sleeping Pills ( ) Scopolamine ( ) Percodan
   ( ) Cortisone OTHERS: _____
10. Please list any medication taken within the last two years or any over-the-counter non-prescription drugs you are currently using:
    _____
    _____

PLEASE CHECK MARK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

( ) Heart Failure	( ) Heart Surgery	( ) Diabetes	( ) Epilepsy or Seizure	( ) Fever Blisters
( ) Heart Attack	( ) Hepatitis A (Infection)	( ) Stroke	( ) Artificial Joints	( ) Cold Sores
( ) Heart Murmur	( ) Hepatitis B	( ) Asthma	( ) Kidney Trouble	( ) Hemophilia
( ) High Blood Pressure	( ) Hepatitis C	( ) Tuberculosis	( ) Liver Disease	( ) Jaundice
( ) High Cholesterol	( ) A.I.D.S	( ) Glaucoma	( ) Drug Addiction	( ) Anemia
( ) Artificial Heart Valve	( ) H.I.V. Positive	( ) Emphysema	( ) Blood Transfusion	( ) Rheumatism
( ) Heart Pacemaker	( ) Cancer or Tumor	( ) Lupus	( ) Sickle Cell Disease	( ) Ulcers
( ) Irregular Heartbeat	( ) Rheumatic Fever	( ) Chemotherapy	( ) Lung Disease	( ) Arthritis
( ) Frequent Cough	( ) Herpes	( ) Sinus Trouble	( ) Cosmetic Surgery	( ) Hay Fever
( ) Thyroid Trouble	( ) Venereal Disease	( ) Depression	( ) Mental Disorder	( ) Shingles

OTHERS: _____
Past or Current Surgeries: _____

Please initial if there are NO Health Concerns: _____ *PLEASE CONTINUE TO BACK PAGE* ⇨

SUNSHINE DENTAL CENTER, LLC

GENERAL INFORMATION

Is another family member a patient at our office? ____ If so, what is their name? _____

Previous Dentist _____ Date of Last Dental Visit _____

Address _____

How did you hear about us? (Online Search /Google, Church, etc. If you were referred to us by another patient, please write their name)_____

What is most important to you in the DENTAL CARE you receive? _____

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE

The undersigned hereby authorizes Sunshine Dental Center, LLC, the Doctor(s) and staff to take X-Rays, study models, photograph(s) or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the doctor to perform any / all forms of treatment , medication and therapy, that may be indicated in connection with the aforementioned patient and further authorize and consent that the Doctor chooses and employs such assistance as the Doctor deems fit. I also understand that the use of anesthetic agents embodies a certain risk and the x-rays, dental records, etc… are the property of Sunshine Dental Center, LLC.

In accordance to the Health Insurance Portability and Accountability Act, Privacy Rule, I authorize Sunshine Dental Center, LLC, Dr. Elaine A. Mesinas D.M.D. and staff to leave messages on my answering machine / voice mail, e-mail or text message as indicated: schedule / confirm appointments, with insurance or accounting / billing information, in response to a call, leave lab results, mail out recall cards with day, date and time of appointment and pre-medication reminder (if applicable), medical clearance information, disclosure referred specialist (oral surgeon, endodontist, etc…) with your name, phone number and information to expedite the treatment.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent(s) is mine, due and payable at the time of services are rendered or when special arrangements are made with the provider. I authorize the use of this signature on all insurance submissions and to release all information necessary to secure the payment of benefits. If for any reason my dental insurance does not fully cover my treatment amount, I am responsible for any unpaid portion. I understand that there will be an added $30 fee for any returned / bounced check(s). In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection and reasonable attorney fees as may be required to effect collection of this note.

Please be informed that there is fee of $50.00 at our discretion, for NO SHOW APPOINTMENTS and SHORT NOTE CANCELLATION of scheduled appointments without a 24 HOUR NOTIFICATION.

SIGNATURE OF PATIENT _____ DATE_____

IF PATIENT IS A MINOR, SIGNATURE OF PARENT / RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT _____

OFFICE STAFF ONLY- REVIEWED BY _____