WAIMĀNALO HEALTH CENTER

Patient Registration

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please CHECK ONE)*
☐ Male ☐ Female

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Gender Identity
☐ Male ☐ Other (please specify): _____
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Genderqueer, neither exclusively male nor female
☐ Choose not to disclose

Sexual Orientation
☐ Lesbian, Gay or Homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else: _____
☐ Don't know
☐ Choose not to disclose

Physical Address	City	State	Zip Code

Mailing Address	City	State	Zip Code

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:
☐ Home Phone ☐ Cell Phone ☐ Day Phone ☐ E-Mail Address

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Housing Status: ☐ **Not Homeless** ☐ **Homeless:** ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Chicano ☐ Mexican American ☐ Not Hispanic/Latino ☐ Cuban ☐ Puerto Rican ☐ Not Reported ☐ Mexican ☐ Spanish (Or another Hispanic, Latino or Spanish Origin)

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race (CHECK ONE below that best describes you):

☐ Native Hawaiian	☐ Fijian	☐ Chuukese	☐ Filipino	☐ Portuguese	☐ White
☐ Other Pacific Islander	☐ Marshallese	☐ I-Kiribati	☐ Chinese	☐ Puerto Rican	☐ Chamorro
☐ Samoan	☐ Micronesian	☐ Kosraean	☐ Japanese	☐ Other Asian	☐ African American/Black
☐ Tahitian	☐ Palauan	☐ Yapese	☐ Vietnamese	☐ Asian Indian	☐ Native American
☐ Tongan	☐ Pohnpeian	☐ Korean	☐ Laotian	☐ All Other (Please specify): _____	

Employer/School Name:
☐ Employed ☐ Student ☐ Unemployed ☐ Retired
☐ Full-Time ☐ Part-Time ☐ Casual ☐ Retired

Occupation:

Family Size (includes self, spouse, & children under 18): _____

Family Income: $ _____ ☐ Monthly ☐ Annual

PARENT/LEGAL GUARDIAN or GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

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Mailing Address	City	State	Zip Code

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:
☐ Home Phone ☐ Cell Phone ☐ Day Phone ☐ Email Address

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Employer Name:
☐ Employed ☐ Student ☐ Unemployed ☐ Retired
☐ Full-Time ☐ Part-Time ☐ Casual ☐ Retired

Occupation:

Family Size (includes self, spouse, & children under 18): _____

Family Income: $ _____ ☐ Monthly ☐ Annual

Patient Registration

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**

PATIENT PORTAL

Patient Portal *is WHC's latest technology that allows you to schedule and view appointments, request medication refills, see lab results, communicate with your health care team, ask questions about your bill, and request your health record.*

Are you enrolled into Patient Portal? ☐ Yes ☐ No **If No, do you need assistance to enroll?** ☐ Yes ☐ No

ADVANCE DIRECTIVES

Do you have an Advance Directive? *(Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond)* ☐ Yes ☐ No

MARKETING & PROMOTIONS

How did you hear about us? (Check all that apply) ☐ Family/Friends ☐ Mailer ☐ Web Search ☐ Banner ☐ Social Media ☐ Print Ads ☐ Other (Please specify): _____

How do you want to stay updated on services and classes? (Check all that apply) ☐ Email ☐ Phone Call ☐ Patient Portal ☐ Text Message ☐ Mailer ☐ Other (Please specify): _____

_____ Initials

I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or organization to process claims on my behalf. I authorize payment of benefits to WHC for services rendered.

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

I authorize WHC to communicate via text, email, and phone call. Message & Data rates may apply. If I am not available, I give WHC consent to communicate a message which will identify the WHC service(s) and/or the date and time of my appointment(s). I may opt out at any time and will need to notify the Front Office.

_____ Initials

MINOR: I consent and authorize Waimanalo Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

_____ Initials

Patient was informed of Waimanalo Health Center's Rights & Responsibilities. Information is available on WHC's website and patient may request a hard copy at any time.

_____ Initials

Patient was informed of Waimanalo Health Center's Notice of Privacy Practices. Information is available on WHC's website and patient may request a hard copy at any time.

_____ Patient or Legal Guardian's Signature Date Signed

_____ Guarantor's Signature Date Signed

FOR OFFICE USE ONLY

Record #_____

Pt Status Type: ☐ Inactive ☐ Scheduled ☐ Non-WHC Active ☐ Active ☐ Dental Patient Only	**Valid ID:** ☐ Scan ID ☐ Update NG Pt Picture	**Insurance:** ☐ Scan Card ☐ Update Info/Card
Collected By: _____ Date: _____	Entered By: _____ Date: _____	

Patient Registration: INSURANCE

Patient Name: _____ MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

PRIMARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

WAIMĀNALO HEALTH CENTER

CONSENT FOR CARE MINOR

I,_____, the undersigned, hereby give Waimānalo Health Center to examine my (son/daughter/ward):

_____ _____

Child's Name Date of Birth

to make such tests as are necessary for his/her diagnosis and care, and to give such treatment as the Waimānalo Health Center physicians deem necessary. This includes diagnosis and care at the Center clinic, at laboratories, X-ray facilities, clinics, emergency rooms and offices of specialists, and psychological tests.

I understand that for major surgery or other major procedures, special explanations will be made to me, and special permission will be requested for me, unless the emergency is too great to wait to contact me.

WHC will inform the parent/legal guardian before starting or making any change the minor patient's medications without first speaking to a parent/legal guardian.

This consent which I am signing is for the ongoing health care of my (son/daughter/ward) until I withdraw him/her from the Center. I understand that it includes consent for general tests, tuberculin tests, applications to skin or mucous membranes, examination of mouth, genitals, rectum, and ears, repair of small cuts, and all other ordinary medical office procedures. I am not hereby consenting to any experimental procedures nor to tests for research or scientific study.

I certify that I have read (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

_____

_____

_____ _____

Parent/Legal Guardian Signature Date

I authorize and consent to any examinations, x-rays, anesthetic, medical diagnosis, immunization, or treatment rendered by the Waimānalo Health Center in the event that my child(ren) is brought to the Center by the following persons:

_____ _____

(Name) (Relationship)

_____ _____

(Name) (Relationship)

_____ _____

(Name) (Relationship)

_____ _____

(Name) (Relationship)

_____ _____

(Signature of Parent or Legal Guardian) (Date)

Child Health/Dental History Form

ADA American Dental Association®
America's leading advocate for oral health

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ☐ F ☐	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ☐ Yes ☐ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	☐	☐
6.	Has the child ever been hospitalized?	☐	☐
7.	Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
8.	Has the child ever received a general anesthetic?	☐	☐
9.	Does the child have any inherited problems?	☐	☐
10.	Does the child have any speech difficulties?	☐	☐
11.	Has the child ever had a blood transfusion?	☐	☐
12.	Is the child physically, mentally, or emotionally impaired?	☐	☐
13.	Does the child experience excessive bleeding when cut?	☐	☐
14.	Is the child currently being treated for any illnesses?	☐	☐
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	☐	☐
16.	Has the child had any problem with dental treatment in the past?	☐	☐
17.	Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
19.	Has the child had any problems with the eruption or shedding of teeth?	☐	☐
20.	Has the child had any orthodontic treatment?	☐	☐
21.	**What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22.	**Does the child take fluoride supplements?**	☐	☐
23.	**Is fluoride toothpaste used?**	☐	☐
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	☐	☐
25.	Does the child suck his/her thumb, fingers or pacifier?	☐	☐
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org