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
☐ Choose not to disclose

*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.

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 ☐ Casual ☐ Part-Time ☐ 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: _____

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

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 ☐ 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 ☐ Casual ☐ Part-Time ☐ Retired

Occupation:

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

Family Income: $ _____ ☐ Monthly ☐ Annual

Patient Registration

Patient Name: _____ MRN: _____

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 Waimānalo Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

_____ Initials

Patient was informed of Waimānalo 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 Waimānalo 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:	**Valid ID:**	**Insurance:**
☐ Inactive	☐ Scan ID	☐ Scan Card
☐ Scheduled	☐ Update NG Pt Picture	☐ Update Info/Card
☐ Non-WHC Active		
☐ Active		
☐ Dental Patient Only		

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

I,_____, the undersigned, hereby give Waimānalo Health Center my consent and permission to obtain historical information, perform physical examinations, order diagnostic tests and give such treatment as the Center physicians deem appropriate for my physical and/or mental health. I understand that this consent is for, but not limited to, obtaining detailed medical and social/psychiatric histories, performance of examinations of mouth, genitals, rectum and ears, repair of minor cuts, tuberculin skin tests, injection of local anesthetics and medications (such as insulin, epinephrine, etc.), injection of immunizations, and all other ordinary medical office procedures.

I understand that for major surgery or other major procedures (such as incision and drainage of abscesses, biopsies, or insertion of such devices as an IUD or LARC) special explanations will be made to me and special permission obtained from me or from an adult family member if I am physically or mentally impaired from giving such consent. In cases of emergency, I hereby give permission for the rendering of all such medical services deemed necessary to stabilize my condition if I am physically or mentally impaired and an adult family member is not readily available.

I understand that this consent extends to diagnostic tests and services rendered at the Waimānalo Health Center clinic, designated laboratories, X-ray facilities, emergency rooms, offices of specialists, and hospitals by Center physicians as deemed necessary for medical care.

This consent is for the ongoing health care of myself until I withdraw from the Waimānalo Health Center and is given voluntarily. By my signature I hereby certify that I am of legal age (18 years old or older) or am an emancipated minor by the definition of State laws.

I understand that I am not consenting to any experimental procedures nor to any tests solely for the purpose of research or scientific study.

I certify that I have read the above (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:

_____

_____

_____

_____

Patient or Legal Guardian Signature

_____

Date

WAIMĀNALO HEALTH CENTER

APPOINTMENT KEEPING AGREEMENT

Patient Information

It is important to keep your medical appointment(s) and to be on time. At Waimānalo Health Center (WHC), our goal is to provide quality medical care in a timely manner. In our efforts to make your visit more comfortable and to minimize your wait time, we have updated and implemented the following policies and procedures.

A. Check-in Policy:

To ensure access and timeliness of medical care, the front office and medical team will inform you to arrive at your designated check-in time, to allow for registration and screening prior to your scheduled appointment time. You are encouraged to:

1. Call by 3:00 PM on the day prior to your appointment to notify us of any changes; and/or
2. If you may be late for your designated check-in time.

B. Late Arrival Policy

We understand that delays may happen, however, it is important to us to see all patients as timely as possible. Not arriving at your designated check-in time is considered late. Clock times on the WHC Front Desk computers will be used to validate ALL designated check-in times.

If you arrive late for your appointment, you may experience one of the following:

1. You may have to wait to be seen;
2. We will ask you to reschedule your appointment for a later time on the same day, or to another day;
3. We will ask you to reschedule to another provider on the same day if available; or
4. If no open appointments exist, you may wait to see if something becomes available (without any guarantees) to the provider's schedule
5. *Kukui Clinic (Behavioral Health) Only:* If you arrive late, you will be seen for the remainder of your scheduled appointment time.

C. Cancellation Policy

If you are not able to make your scheduled appointment, please call us at (808) 259-7948 by 3:00 PM on the day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 PM on Friday. Appointments are in high demand, and your early cancellation will give another person access to timely medical care.

1. If you are not able to speak to someone, please leave a message with your name, phone number, your appointment date/time and request for rescheduling or cancellation reason.
2. If you receive appointment text reminders, you may reply with an "X" to cancel your appointment.

D. No Show Policy:

All patients who miss three (3) appointments dates in a three-month period, will be considered a chronic no show. After the third missed appointment date, you will be placed on a "Same Day Only" status. You may return to a regular status at the end of the rolling three-month period.

Waimānalo Health Center is committed to providing exceptional care. Your help in keeping your appointments enables us to provide better and timelier care for you and all of our patients.

I have read and consent to these terms.

Print Patient Name	Print Legal Guardian Name	Relationship
Patient Signature (Parent/Legal Guardian if under 18)	Date	

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

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

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____