Peter Fay DMD Erik Wong DMD

• prosthodontists •

Name: _____ Birthdate: _____ ☐ Male ☐ Female
Last First Middle Initial

Address: _____
(mailing) Street City State Zip Code ☐ Single ☐ Married

Address: _____
(residence) Street City State Zip Code

Telephone (home): _____ (cell): _____ Social Security # _____

Telephone (work): _____ ext: _____ Employer: _____

E-Mail Address: _____

Name of Spouse: _____ Social Security # _____

Birthdate: _____ Employer: _____

Person Responsible for This Account: _____

In Case of Emergency Who Should We Notify? _____ Telephone: _____

Do You Have Dental Insurance? ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____ Dental Plan #: _____

Is There Secondary Dental Insurance ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____ Dental Plan #: _____

Health History:

Name of Your Physician: _____ Date of Last Physical: _____

Are You Taking Any Medications? ☐ Yes ☐ No If Yes, What? _____

Do You Have Any Allergies (or Adverse Reactions) To Any Medications, Latex Materials Etc… ☐ Yes ☐ No

If Yes, What? _____

Please Circle Any of The Following That Apply:

Heart Problem	AIDS	Tuberculosis	Artificial Joints	Psychological or
Rheumatic Fever	HIV Antibodies	Emphysema	Abnormal Bleeding	Psychiatric Treatment
Hi Blood Pressure	Cancer	Asthma	Ulcers	Other: _____
Lo Blood Pressure	Hepatitis	Diabetes	Fainting	
Pacemaker	Tobacco Use	Epilepsy	Pregnant	**None Apply**

How were you referred to our office? _____

I grant authority to Erik K Wong, D.M.D. and his practice auxiliaries to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics, that are deemed necessary and advisable.. Patient and/or legal guardian/parent will be informed before treatment is performed.

I authorize the practice of Erik K Wong, D.M.D. to release any information necessary to expedite insurance claims. I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.

I consent to the taking of photographs and videos before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I hereby certify the above to be true and correct to the best of my knowledge.

Authorized Signature: _____ Date: _____

Your signature is a file signature for insurance and credit card purchases

140 HOOHANA ST. SUITE 300 KAHULUI, HAWAII 96732 808.871.6283 808.871.7686 fax

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Name _____ Date _____

Our practice is committed to providing each of our patients with individualized private care treatment consistent with their particular needs, wants, and values. By answering the following questions candidly you will help us to better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1) What prompted you to contact our office for an appointment? _____
_____

2) Does dental treatment make you nervous? ❑No ❑Slightly ❑Moderately ❑Extremely

3) Have you ever had any serious trouble associated with previous dentistry? ❑Yes ❑No

4) Do you use the following?

Toothbrush	❑Yes ❑No	How often? _____
Dental Floss	❑Yes ❑No	How often? _____
Other Oral Hygiene Device	❑Yes ❑No	What and how often? _____
		_____

5) Do you have or have you ever had any of the following?

Orthodontic treatment (braces)?	❑Yes ❑No	Loose Teeth?	❑Yes ❑No
Clicking/popping jaw?	❑Yes ❑No	Teeth sensitive to hot, cold, sweet?	❑Yes ❑No
Difficulty opening or closing jaw?	❑Yes ❑No	Teeth sensitive to chewing?	❑Yes ❑No
Clenching or grinding?	❑Yes ❑No	Bleeding or sore gums?	❑Yes ❑No
Shift or change in bite?	❑Yes ❑No	Unpleasant taste or bad breath?	❑Yes ❑No

Treatment for periodontal disease (gum disease, pyorrhea)? ❑Yes ❑No

6) On a scale of 1 to 10 (1 being terrible and 10 being perfect) how healthy do you think your mouth is? _____

7) On a scale of 1 to 10 (1 being terrible and 10 being perfect) how healthy would you like your mouth to be? _____

8) Are you happy with the appearance of your teeth? ❑Yes ❑No
If you answered 'No' and we could wave a magic wand over your head and instantly change anything about the appearance of your teeth what would you change? _____
_____

9) Do you expect to keep your teeth for the rest of your life? ❑Yes ❑No

10) What are some questions about dentistry and your oral health that you have never had adequately answered? _____
_____
_____

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the offices of Erik K. Wong, DMD. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this pffoce with respect to my protected health information. The statement of Privacy Practices is also posted in the facility.

Erik K. Wong, DMD reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

Additional Disclosure Information		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ Yes	☐ No
Any member of my immediate family: (Spouse, Children, Children's Spouses)	☐ Yes	☐ No
Any member of my extended family: (Parents, Grandchildren)	☐ Yes	☐ No
Other:	☐ Yes	☐ No
Name of patient (please print):		
Patient signature:		
Patient's personal representative (please print):		
Personal Representative's signature:		
Representative's Telephone number:		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provider Prior to Treatment?	☐ Yes	☐ No	Date Statement Provided:
Reason for not obtaining patient signature	☐	Needed more time to review Statement	
	☐	Wanted to consult another person before signing	
	☐	Physically unable to sign	
	☐	No reason offered	
	☐	Other:	

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