Hawai'i Island Community Health Center

Hawai'i Island Community Health Center
Dental Medical History Form

Child's name: _____Nickname:_____Sex: (M) (F)

Purpose of visit: _____Date of Birth: _____

Concerns: _____

Name and age of brothers/sisters: _____ Is your child adopted? (Y) (N)

Child's Interests: _____Name of Pet(s):_____

Does your child have any special needs? _____Any Phobias?: _____

Child's learning: (slow) (average) (accelerated) Child's school: _____

Who may we thank for referring you to us?: _____

Health History

Child's Pediatrician: _____ Last Physical: _____

Is your child under a physician's care now? (Y) (N) If yes, reason: _____

Immunizations up to date? (Y) (N)

Is your child taking any medications (including over the counter)? (Y) (N) If yes, please list_____

Any history of hospitalization or surgery: (if yes, when)_____

Does your child have any allergic reactions? Yes____ No____ (if yes, please check all that apply)

__Peanuts/tree nuts	__Soy	__Latex/Rubber	__Pollen/Dust/Environmental	__Anesthetics
__Eggs	__Metals	__Animals	__Berries	__Acrylic
__Wheat/Gluten	__Milk	__Dyes/Coloring	__Antibiotics (i.e. Amoxicillin)	

__Others: _____

Has your child had a history or difficulty with any of the following:

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune disorder	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Murmur	Y N
Allergies to Medications	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down Syndrome	Y N	Rheumatic Fever/heart	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N
		HIV	Y N		

Other: _____

Dental History

Is this your child's first dental visit? (Y) (N) If no, previous dentist: _____

Date of last visit: _____How was his/her experience? _____Were any x-rays taken? Y N Child's attitude towards the dentist or dental care:_____

Has your child had any injuries to teeth, mouth or head? Y N If yes, please describe: _____

Is your child doing any of the following: Please circle: thumb/finger sucking pacifier nail biting lip sucking mouth-breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated Y N Does your child take fluoride supplements Y N

Does your child use fluoridated toothpaste? Y N How often does your child brush his/her teeth?_____

With adult supervision Y N How often does your child floss?_____

How may we help to make this visit a positive experience for your child?_____

_____

Parent Signature: _____Date: _____

FOR OFFICE USE ONLY

Weight: _____

Reviewed and Entered by Asst/RDH: _____

Reviewed by Dr: _____

Patient Responsibility for Payment for Dental Services

Dear Dental Patients,

To allow us to continue providing you with quality dental services all individuals and families are responsible for the following:

1. Pay their remaining balances in full prior to receiving further non-emergent dental care. If your existing balance is not paid in full, we will not be able to continue elective care and you will be rescheduled when the balance has been paid in full.
2. Payment is due in full at the time of your visit.
3. No one with a dental emergency will be denied services, regardless of their ability to pay; however, elective/follow-up dental work will not be provided until all outstanding dental balances are paid in full.
4. If a patient arrives for their elective dental visit and is unable to pay their estimated charge, that dental appointment will be considered as a "no-show" according to our Dental Program Appointment Compliance Policy.

Steven C. Pine, DDS
Director of Dental Services

I have read and understand, and agree to the above policies.

Printed name of Guarantor:_____

Signature of Guarantor:_____

Date:_____

NO-SHOW POLICY ACKNOWLEDGEMENT

(Effective 02/ 05/ 2018)

Definition:

A no-show is defined as a patient who has a scheduled appointment and fails to appear without calling the Center to cancel or reschedule their appointment at least 24 hours prior to their appointment time.

Policy:

1. If a patient is unable to make their scheduled appointment, they are to call at least 24 hours before their appointment to cancel or reschedule.

2. Patients will have the opportunity to reschedule up to three (3) missed appointments.

3. Repeated no-shows on a consistent basis during a six-month period may result in a patient's scheduled appointment being double booked and potentially resulting in longer wait times for a period of six (6) months.

Patient Acknowledgement:

_____ _____

Signature *Date*

_____

Print Name

Hawai'i Island Community Health Center

Please fill in all information requested, as it helps us to better serve you.

Patient information is confidential and only used for Hawai'i Island Community Health Center purposes.

PATIENT INFORMATION SUMMARY:

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ Sex at Birth: () Male () Female

Mailing Address: _____

City:_____State:_____Zip: _____

Street Address (*Required for Prescriptions*): _____

City:_____State:_____Zip: _____

Home Phone:_____Work Phone:_____Cell: _____

Email: _____

Marital Status:	**Race:**	**Ethnicity:**	**Primary Language:**
Single ()	Native Hawaiian ()	Latino/Hispanic ()	English ()
Married ()	Other Pac. Islander ()	Not Hispanic ()	Spanish ()
Legally Separated ()	Asian ()		Marshallese ()
Divorced ()	Black/African American ()		Russian ()
	White/Caucasian ()		Filipino ()
	Native American Indian/Alaska Native ()		Chinese ()
	More than one race ()		Japanese ()
			Sign Language ()
			Interpreter? Yes () No ()

Employment Status:

Employed () Employer (where person works):_____Phone #_____

Occupation (what person does): _____

Retired () Disability () Self Employed () Unemployed () Part-time student () Full-time student ()

Hawai'i Island Community Health Center

Person(s) Who is Responsible to Pay *(Guarantor is parent/guardian for patients under 18 years of age and is the patient themselves from 18 years old and up)*:

Last Name:_____First Name:_____Middle Initial: _____

(If Mother) Maiden Name:_____

Date of Birth: _____ Relationship to patient: Self () Spouse () Parent/Guardian () Other ()

Address: _____

City: _____ State:_____Zip: _____

Phone #: _____ Email:_____

HOUSEHOLD & FINANCIAL INFORMATION:

Please the complete information listed below. This section helps us receive funding to provide services to the community. Personal identifiable information is never reported and is for grant reporting purposes only. In addition, this information may qualify you to receive additional discounts (medications, Sliding Fee Scale or other services).

Monthly Gross Family Income: Family Size: _____

__$0-$500 __$500-$1000 __$1500-$2000 __$2500-$3000

__$3500-$4000 __$4500-$5000 __$5500-$6000 __No Income

_____Other (please specify)

Farm Worker Status:	**Public Housing:**	**Veteran:**	**Disabled:**
Migrant () Seasonal () Not a farm worker ()	Yes () No ()	Yes () No () *If yes:* Military discharge: Yes () No () Discharge date:_____	Yes () No ()

Homeless:

Yes ()
No ()
Homeless Shelter ()
Transitional Housing ()
Street ()
Other ()

Refugee Status:

Yes () No ()
If Yes:
Country of Origin _____

Hawai'i Island Community Health Center

INSURANCE INFORMATION (Need a copy of all insurance cards):

Primary Insurance Co._____ **Identification #:** _____

Patient's relationship to person having insurance: Self () Spouse () Child () Other ()

Subscriber or Member:

Last Name: _____ First Name:_____ Middle Initial: _____

Date of Birth: _____ Male () Female ()

Address: _____

City:_____ State:_____ Zip: _____

Secondary Insurance Co._____ **Identification #:** _____

Subscriber or Member:

Last Name: _____ First Name:_____ Middle Initial: _____

Date of Birth: _____ Male () Female ()

Address: _____

City:_____ State:_____ Zip: _____

ALTERNATE CONTACT INFORMATION:

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ May we speak to this person about your health? Yes () No ()

May we speak to anyone else about your health? Name: _____

Relationship: _____ Phone: _____

Parent/Legal Guardian (if under 18 years of age):

Name: _____ Relationship: _____

Phone: _____

Hawai'i Island Community Health Center

If you have a primary care giver please list their name below:

Name: _____ Phone: _____

Do you have an Advance Directive: Yes () No () I decline to provide/discuss Advance Directives ()

***Please provide us with a copy. An Advance Directive form is available to you upon request.

PERMISSION AND RELEASE:

- Hawai'i Island Community Health Center (HICHC) does not participate with Kaiser. I do not have Kaiser.
- If we do not participate with your insurance provider (such as Kaiser) you are responsible for full payment.
- I have disclosed all information about finances(money) and insurance accurately and I am responsible to notify HICHC about any changes in finances (money) or insurance.
- I authorize HICHC, its providers and staff to provide insurance companies with any information needed to receive payment for my visits. This signature may be used on all insurance forms.
- I give permission to Hawai'i Island Community Health Center and all its groups (medical, dental, behavioral, health education, case management) to share information so my family and I receive the best care.
- Today's co-pay or charges a minimum payment for the visit. Any additional charges that are not covered by your insurance will be billed to you. **I understand I am responsible for the balance due by me after insurance and/or slide has been applied.**
- I understand that HICHC does not accept Worker's Compensation and No-Fault (MVA) Insurance and I will disclose this to HICHC so I can be referred to a doctor in the community who can see me.
- All of the information that I am presenting is correct and complete.

By signing I agree to the above permissions and releases

_____ _____

Signature (Signed by) (Patient/Person Responsible/Legal Guardian) Date

_____

Print Name

_____ _____

Print Name of Witness, if someone other than patient is signing Date

Hawai'i Island Community Health Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hawai'i Island Community Health Center keeps a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. Hawai'i Island Community Health Center will not disclose your record to others, unless you direct us to do so of unless the law authorizes of requires us to do so. You may see your record or get more information about it by contacting us.

Hawai'i Island Community Health Center's Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Hawai'i Island Community Health Center Notice of Privacy Practices.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Printed name of signed on behalf of patient Relationship

I have read the Patient's Rights and responsibilities: _____

This form will be retained in your medical record Initials

Hawai'i Island Community Health Center

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

- To be treated with dignity and respect
- To know the name and professional status of people serving you
- To confidentiality of your medical records
- To receive complete and accurate information about your health related concerns
- To know the effectiveness and possible side effects of all forms of treatment
- To participate in choosing a form of treatment
- To receive verbal education, counseling, and written materials related to your medical condition and/or treatment
- To accept or refuse any care or treatment
- To select and/or change your health care provider
- To review your medical records with the clinical staff provider
- To receive information about services and related costs

Patient Responsibilities

- To provide medical history to the clinical staff including medical records and a list of current medications.
- To provide HICHC with documented proof of income as required by the state of Hawaii (Sliding Fee Applicants only).
- To notify HICHC of any changes in insurance, income status, addresses and phone numbers.
- To treat other patients and HICHC staff with respect. Swearing, threatening, or aggressive behavior could result in immediate discharge from this clinic.
- To notify the HICHC, if you will be late or are unable to make your appointment --you may be rescheduled if you are at least 15 minutes late.
- Your medical, dental, and prescription coverage is a policy between you and your insurance company. Contact them if you have questions about your coverage.
- To pay, on the date of service, any amount due, or an item that may not be covered.
- When accepting care, you agree to follow the treatment plan made by your physician.
- To be responsible for your medications. Request for refills will require at least 48 hours notice or an office visit as required by your physicians.
- To be responsible for your child or children's behavior while in the waiting room or exam room, so as not to disrupt others. Please provide adult supervision for your child/children during your appointment or reschedule your appointment if this cannot be arranged. HICHC staff will not be responsible for minor children.
- No pets allowed within the clinic except service dogs.

By signing below I understand and agree to the above "Patient Rights and Responsibilities."

_____ _____

Signature of Patient (or Responsible Party, if Minor) Date

_____

Print Name

Hawai'i Island Community Health Center

75-5751 Kuakini Highway, Suite 203, Kailua-Kona, Hawaii 96740 - **Administration** (808) 326-3878 - Fax (808) 329-9370

Video/Photography Release Form

I hereby consent to and authorize the use and reproduction by the Hawai'i Island Community Health Center (HICHC), or anyone authorized by you, of any and all photographs, videotapes, audiotapes involving me and/or my children and family members that were taken on this day. All the forms of media shall be the property of HICHC and can be used for any purpose whatsoever that will assist in promotion and marketing the activities of HICHC.

In signing this release, I acknowledge I have received no compensation and do not expect compensation now or in the future.

Persons covered by this release: _____

_____

_____

_____

_____

_____ _____ _____

Name (please print) Authorizing Signature Date

Hawai'i Island Community Health Center (HICHC) is requesting that you fill out the attached form and have it notarized to allow another adult to bring your child (or children) to the clinic for an appointment, **in the event that you are unable to do so.** This is a state requirement that a minor cannot be seen or treated without the parent or a legal guardian present to consent except for some specific circumstances. HICHC will require the attached documents **signed by you and notarized to give permission for another adult (18 years old and over) to bring your child and authorize the other adult power to view medical records and make any type of health care decision on behalf of your child (children).** This document will be kept in our files and will be used to verify the identification of the adult who will be bringing your child. If there is more than one person you would like to designate, please provide their names and relationship to your child (children).

We appreciate your cooperation and assistance with this requirement. We have a staff member who can notarize the document at no cost, so please let us know if you request her services.

Hawai'i Island Community Health Center

HAWAI'I ISLAND COMMUNITY HEALTH CENTER
Minor (Child) Power of Attorney Form

Please print clearly.

I (or we),_____, (circle relationship: mother, father, parents, legal guardian(s)) living at home address(es) _____
_____,
give rights to make parental or guardian decisions on behalf of the Minor(s) named below to the person(s) listed below as Attorney(s)-in-Fact, and grant said Attorney(s)-in-Fact Powers to view medical/dental records and make any type of health care decision for my (our) child/children.

Attorney(s)-in-Fact (List adult(s) age 18 and over to whom you give the above rights on behalf of your child (children)):
Name:_____ DOB:_____ Relationship to child:_____

Name:_____ DOB:_____ Relationship to child:_____

Name:_____ DOB:_____ Relationship to child:_____

List the name(s) of your **Minor** child or children (age under 18 years):
Name of Child:_____ Date of Birth_____
Name of child:_____ Date of Birth:_____
Name of child:_____ Date of Birth:_____

Parent Signature(s):_____ Date:_____.

Witness (1): _____ Date:_____

Witness (2):_____ Date:_____

Acceptance by Attorney-in-Fact: The undersigned Attorney-in-Fact acknowledges and executes this Power of Attorney, and by such execution does hereby affirm that I: (A) accept the appointment; (B) understand the duties under the Power of Attorney and under the law.
Attorney(s)-in-Fact's Signature(s) _____

STATE OF HAWAII
COUNTY OF _____
On this_____ day of_____ 20___, before me personally appeared
_____, to me known to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that he/she/they executed the same as his/her/their free act and deed.

_____
Notary Public
My Commission Expires: _____

Document Date:_____ # of Pages: _____
Notary Name: _____ Third Circuit
Commission Number: _____
Document Description:

_____

_____
Notary Signature Date