Welcome to Our Office!

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

PATIENT INFORMATION Today's Date _____

Patient's name (first, MI, last) _____ Preferred name _____

If minor, parents' names & phone numbers_____

Birthdate _____ Age _____ Gender ❑ Male ❑ Female Last 4 of Social Security # _____

Home phone _____ Work phone _____ Mobile phone _____

Email address _____

Best contacted via ❑ Home# ❑ Work# ❑ Mobile# (call) ❑ Mobile# (text) ❑ Email (check all that apply)

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

❑ Married ❑ Widowed ❑ Single ❑ Separated ❑ Divorced ❑ Partnered for ____ years ❑ Minor

Spouse's name _____ Birthdate _____ Spouse's employer _____

Whom may we thank for referring you to our office? _____ ❑ Insurance Website ❑ Internet

BILLING, CREDIT, AND INSURANCE INFORMATION ❑ Not covered by dental insurance

Who is responsible for this account? _____ Relationship to Patient: _____

Primary Dental Insurance Co. & Group # _____

Subscriber Name _____

❑ Self ❑ Spouse ❑ Parent

Subscriber Date of Birth _____

Subscriber Policy Number _____

Secondary Dental Insurance Co. & Group # _____

Subscriber Name _____

❑ Self ❑ Spouse ❑ Parent

Subscriber Date of Birth _____

Subscriber Policy Number _____

DENTAL HEALTH HISTORY

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____ Date of last dental X-rays: _____

How often do you floss? _____ How often do you brush? _____

Please check to indicate if you have had any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Cigarette, pipe or cigar smoking
- ❑ Clicking or popping jaw
- ❑ Dry mouth
- ❑ Fingernail biting
- ❑ Food collection between the teeth
- ❑ Foreign objects, biting or holding in mouth (i.e. pens, needles)
- ❑ Grinding or clenching teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tiredness
- ❑ Lip or cheek biting
- ❑ Loose teeth or broken fillings
- ❑ Mouth breathing
- ❑ Mouth pain when brushing
- ❑ Orthodontic treatment/braces/invisalign
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

MEDICAL HEALTH HISTORY

Name of your physician:_____ Date of last visit: _____

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Acid Reflux
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anemia or other blood disorders/problems
- ❑ Anxiety/Nervous Problems or Psychiatric Care
- ❑ Artificial joint/valve/other artificial placement
- ❑ Arthritis or Rheumatism
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding abnormally after extractions, surgery, or trauma
- ❑ Chemotherapy
- ❑ Cancer or tumors, esp. on head or neck
- ❑ Cortisone Treatments
- ❑ Diabetes
- ❑ Epilepsy/seizures/fainting spells or vertigo
- ❑ Glaucoma
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Hemophilia
- ❑ Hepatitis (specify type(s): _____) or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Migraine headaches or frequent headaches
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Radiation Treatment (any history of)
- ❑ Rheumatic fever/Scarlet fever or rheumatic heart disease
- ❑ Sinus Trouble/Hay Fever
- ❑ Stroke
- ❑ Thyroid Problems (hypo or hyper)
- ❑ Tuberculosis or other lung/respiratory conditions
- ❑ Ulcers

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine or other narcotics
- ❑ Latex materials
- ❑ Local anesthetics ("Novocain")
- ❑ Milk or dairy
- ❑ Penicillin/amoxicillin or other antibiotics
- ❑ Pine Nuts
- ❑ Sulfa drugs
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other: _____

Women:

- ❑ May be pregnant (expected delivery date: _____)
- ❑ Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

_____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Bennett G.M. Gum all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Office of Dr. Bennett G.M. Gum DDS Inc. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient (or parent) _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Provider's Notice of Privacy Practice.

Signature of patient (or parent) _____ Date _____

Relation to patient if patient is a minor _____

FINANCIAL POLICY
BENNETT G.M. GUM, DDS

Thank you choosing us for your dental care. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment. If you'd like to obtain a copy of this financial policy, please request a copy from the front desk.

- **Your portion of any payment (including deductibles) is due at the time of service.**

- We accept cash, checks, VISA, Mastercard, American Express and Discover. We also participate with Care Credit.

PARTICIPATING DENTAL PLANS

We are happy to bill HDS, HMSA, HMAA, Delta, and United Concordia insurances for their portion of your payment. Once we receive correct payment, we will make our contractual adjustment and bill you for any additional balance due.

NON-PARTICIPATING DENTAL PLANS

As a courtesy to you we will bill your insurance carrier once you provideus with complete insurance information. **Your insurance policy is a contract between you and your insurance company. We are not party to that contract.** If your insurance company has not paid your account within 30 days, the balance may be assessed to you for payment. You should remit payment within 30 days or contact your insurance company to check the status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area.

PAST DUE BILLS

Please not that if your balance is unpaid for 90 days, your account will be eligible for assignment to a collection agency without further notification.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

X_____ _____
Patient/Responsible Party Date

_____
PRINT NAME

Bennett G.M. Gum DDS Inc.
1010 South King Street, Suite 403
Honolulu, HI 96814
(808)589-2486

RELEASE OF INFORMATION

Patient Name:_____

Date of Birth: _____ Phone #: _____

I authorize release/discussion of confidential dental information to the following contact persons:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

*I authorize **BENNETT G.M. GUM, DDS, INC.** to disclose/request my health information including copies of records as necessary to/from:*

1. *Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.*

All medical information with no exceptions will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Signature of Patient/Legal Guardian: _____ Date: _____