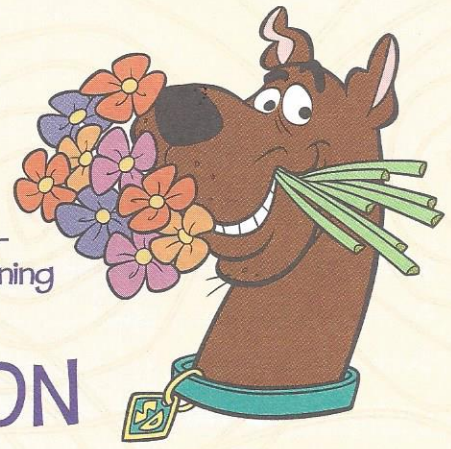


SCOOBY-DOO! WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION

Date _____

Name of Minor/Child _____
Last Name First Name Initial

Sex M F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

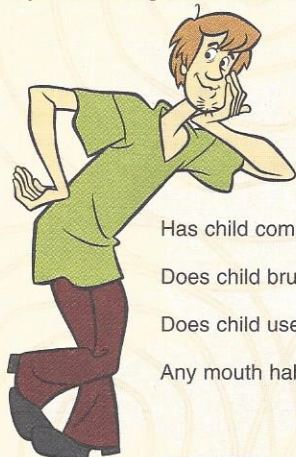
Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you _____

INSURANCE

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small>	Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small>
Employer _____	Employer _____
Soc. Sec. # _____ Birthdate _____	Soc. Sec. # _____ Birthdate _____
Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____	Plan Name _____
Phone No. _____	Phone No. _____
Address _____	Address _____
Group # _____	Group # _____
Policy # _____	Policy # _____
Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's Medical Assistance I.D. # _____

DENTAL HISTORY



Date of last visit to a dentist _____ For what service? _____

Has child complained about dental problems? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is fluoride taken in any form? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does child brush teeth daily? <input type="checkbox"/> YES <input type="checkbox"/> NO	Any injuries to mouth, teeth, head? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does child use floss every day? <input type="checkbox"/> YES <input type="checkbox"/> NO	Any unhappy dental experiences? <input type="checkbox"/> YES <input type="checkbox"/> NO
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

YES NO

Is Minor/Child under care of physician now? Medications _____

Receiving any medication or drugs? _____

Ever been hospitalized? _____

Ever had surgery? Allergies _____

Is there excessive bleeding when cut? _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian _____ Date _____

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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 hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian _____ Date _____

UPDATE

(To be completed at later visit)

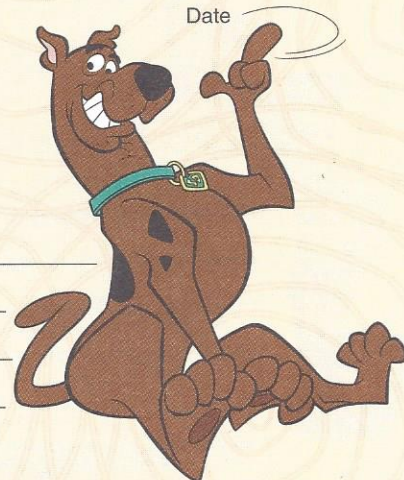
Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: AA Windward Dental Group, LLC

Telephone: (808) 247-4118 Fax: (808) 247-5115

E-mail: spitdr@hotmail.com

Address: 45-1144 Kamehameha Hwy. Suite 401 Kaneohe, HI 96744

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.