Welcome

We are pleased to welcome you 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 dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Pharmacy Name _____ Phone _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath	❑ Y ❑ N Food collection between teeth	❑ Y ❑ N Periodontal treatment	❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Bleeding gums	❑ Y ❑ N Grinding or clenching teeth	❑ Y ❑ N Sensitivity to cold	❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Clicking or popping jaw	❑ Y ❑ N Loose teeth or broken fillings	❑ Y ❑ N Sensitivity to hot	❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Do you wish your teeth were straighter? ❑ Y ❑ N

Do you wish your teeth were whiter? ❑ Y ❑ N

Are you unhappy with any fillings, crowns or bridges? ❑ Y ❑ N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Promise

Dear Patient

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Dr. Scott Wardwell, DDS

1150 S. King St., Ste. 601 • Honolulu, HI 96814 • (808) 946-0713

Protecting Your Confidential Health Information is Important to Us

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the strieter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s): _____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

OFFICE POLICIES

Please note that this outline states your responsibility as a patient of Dr. Scott Wardwell, and addresses the possibility of incurring out of pocket expenses and diagnostic treatment frequency requirements.

Insurance Claims/Payments:

As a courtesy, Dr. Scott Wardwell will file an insurance claim for you; however, in the event that your insurance company denies payment for any reason or has not paid your claim within 60 days, you will be responsible for any balance due. We only bill your dental insurance company and are not involved in the management or benefit outline of the contract you're enrolled in. It is also your responsibility to provide us your current address, billing information and insurance information by carrying an updated insurance card and by following up on any issues with the insurance carrier. We are a dental care provider; our relationship is with the patient and not with the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility for the date of service rendered.

Estimates & Co-Pays:

Estimated Co-Pays presented to patients either by verbal statements or in written format are due in full at time of service; we accept cash, check, and credit card. Quoted estimate prices are valid for 60 days. Your treatment plan is based on expected insurance reimbursements but is not a guarantee of benefits to be paid by your insurance. It is an estimate. We strive to be accurate in our co-pay calculations, but all insurance companies have a disclaimer when obtaining your benefit outlines that states, "Information provided is never a guarantee of payment." That being said we do the math off of your benefit outline hoping they will honor their commitment to you and pay diligently on your behalf. If your insurance does not pay within 60 days, or remits less than expected reimbursement the remaining portions then become patient balance as well. I the undersigned understand that billing my insurance is a courtesy extended to me thru Dr. Wardwell's office and he does not bear responsibility for my insurance policy. I am agreeable to these billing terms. I hereby give consent and acknowledgement of the office policies.

*I understand that I am ultimately responsible for either a co-pay portion along with state excise tax, & or full service charges incurred thru denied claims.

*If you have no insurance plan, you will be required to pay 100% of the visit charges at the time of your visit.

Exam & X-Ray frequency:

Exams are a critical part of preventive health care. In conjunction with x-rays it gives doctors a complete diagnostic overview of your oral health.

X-rays are an invaluable part of dental treatment because they can detect damage to teeth and gums not visible during exams. Dr. Wardwell is looking for decay, bone loss, abscesses, infections & multiple possible pathology abnormalities developing such as cysts or tumors.

In consideration of this Dr. Wardwell follows a standard of care that requires all patients take in office, minimally, an annual set of 4 Bite Wing X-rays along with an annual exam to be administered as part of our office policy. New patients will be required to have a current (not more than 1 yr old) full set of x-rays on file. Those x-rays for new patients can be transferred over from a prior office digitally via email or we will take upon your first appointment.

Additional key points:

- The ADA, in collaboration with the FDA, developed recommendations for dental radiographic examinations to serve as an adjunct to the dentist's professional judgment of how to best use diagnostic imaging.
- Radiation exposure associated with dentistry represents a minor contribution to the total exposure from all sources, including natural and man-made.

- State laws, and insurance company regulations also set specific requirements.

Parking validations:

Please bring your validation ticket up to the office at your appointment. Our goal is to cover most, not all, of your parking fee when you visit. The aim is to keep your total out of pocket cost to no more than $2.00 per appointment.

No Show, & Cancellation Fees:

As a courtesy to our staff and other patients we request you cancel your weekday appointments with at least a 5 days notice of cancellation. Otherwise there is a $50 Short Notice Cancelation fee applied to the account for these missed weekday appointments. If two or more family members are scheduled on the same weekday a 7 day notice is required. There will be a $50 broken appointment fee, per person for every hour scheduled, applied to broken weekday appointments. All Saturday appointments are subject to a 7 day notice of cancelation, or a $75 Short Notice Cancellation fee per person for every hour scheduled will be automatically charged to each account.
All NO SHOW missed appointments are automatically charged $50 for weekday or $75 for Saturdays at a per hour per person rate. Repeated cancellations or missed appointments will result in loss of future appointment privileges. *Please note that any patients arriving 15 minutes or later after their scheduled appointment time may be rescheduled and/or charged a broken appointment fee as well.

After hour charges:

There are occasions where dental emergencies happen after hours or on weekends that the office is not open. If you contact the doctor after hours and he sees you at the office then an "After Hours" Emergency visit charge of $250 will be charged to your account. Also there are occasions where phone consultation fees are applied to patient ledgers. Phone consults are billed at $50 for every 15 minutes. Both of these fees are not billable to your dental insurance, and are a direct out of pocket expense by you the patient.

Accounts in Collections:

If your account has a delinquent balance, it will be transferred to a collection agency after 30 days. A $50 fee will be added to your account upon transfer. Other charges may include, but is not limited to attorney's fees and other costs that Dr. Scott Wardwell considers necessary. To avoid collections please understand our office policy is payment in full of all co-pays at time of service. Once being placed in collections we will not be able to schedule any future dental appointments until your account balance is paid in full.

Returned Checks:

All returned checks will be subject to a $39 NSF fee. You will be required to pay your original balance in addition to the $39 NSF fee before being seen for another appointment. As a result you will be placed on a cash/credit card only payment method for future appointments.

By signing I acknowledge that I am in acceptance of all the office policies listed above:

Patient name: _____

_____ Date: _____

Signature of Patient & or Guardian of

*revision dates:
August 2019
April 2020