Big Island Smiles
Pediatric Dentistry & Orthodontics

Patient Information:

Name: _____ Preferred Name: _____ M/F

Mailing Address: _____ City: _____ Zip code: _____

Physical Address: _____ City: _____ Zip code: _____

DOB: _____ Phone: _____ Email: _____

Primary Insurance Name: _____ Subscriber ID: _____

Subscriber Name:_____ DOB: _____

Responsible Party:

**If patient is responsible party, please move on to Health History

Name: _____ Relationship to Patient: _____ DOB: _____

Mailing Address: Same as above Y ☐ N ☐ If no, please provide Mailing Address.

_____ Phone: _____ SSN: _____

Health History:

Are you allergic to any of the following?

☐ Penicillin ☐ Latex ☐ Aspirin ☐ Codeine ☐ Metals ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other: _____

Please list all medications: _____

Do you have any of the following?

❑ AIDS/HIV ❑ Alzheimer's ❑ Asthma ❑ Autisim ❑ Cancer _____ ❑ Cold sores/Fever blisters ❑ Diabetes ❑ Drug Addiction ❑ Epilepsy or Seizures	❑ Fainting Spells/Dizziness ❑ Hepatitis _____ ❑ High / Low Blood pressure ❑ High / Low Blood pressure ❑ Headaches ❑ Joint Replacement ❑ History of Drug Addictions	❑ Heart Condition: _____ ❑ Joint Replacement ❑ Kidney Problems ❑ Liver Disease ❑ Lung Disease ❑ Pain in Jaw ❑ Psychiatric Care ❑ Sinus Trouble	❑ Stomach problems ❑ Stroke ❑ Tumor or Growths ❑ Thyroid Disease For Women: ❑ Are you pregnant? ❑ Are you nursing? ❑ Are you using oral contraceptives?

Any other medical conditions not listed above: _____

I certify that I have read and understood the above information to the best of my knowledge.

Patient/Parent Guardian Signature: _____ Date: _____

HIPPA Compliance Acknowledgement:

I have read the HIPPA Compliance Form or NPP. I understand that I can be given a copy from the office as soon as requested. By signing below, I understand the Notice of Privacy Practices and agree to it's terms.

Patient/Parent Guardian Signature: _____ Date: _____

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Thank you for choosing Big Island Smiles! Below you will find our office guidelines. Please read through and consent. Please let us know if you have any questions or concerns.

Appointment Guideline: We have reserved time just for you! Please be considerate and arrive on time for your scheduled visits. We do our best to stay on time but unplanned tardiness will ALWAYS run our staff behind. If you need to cancel or move an appointment, no problem! Please allow our staff 48 hours notice prior to canceling your scheduled appointments to avoid any cancelation fees. Great preparation goes into each appointment so we appreciate the advance notice to allow us the proper time to fill our schedule.

Insurance/Estimates: Our team strives to be as accurate as possible in all estimates given, however, there are many insurance companies and thousands of plans, each with customized frequencies and limitations. We will bill your insurance on your behalf and after they have made their final payment/decision, if needed, we will bill you the difference. Please understand that in signing and acknowledging this form, you fully understand that the total amount both "estimated" patient portion and "estimated" insurance portion belongs solely to the Responsible Party. *There is NEVER a guarantee of insurance benefits!*

Payment: Payment is collected at the time of service. We accept multiple credit cards, cash, Carecredit, and checks. If any checks are returned, there is a $20.00 fee applied to the account immediately and all future appointments for the family will be removed from the schedule until the balance is cleared.

***ALL FAMILY MEMBERS with accounts that reflect unpaid balances are at risk for scheduling limitations. Please do not hesitate to speak with us about your balance. We can resolve the matter together!*

By signing below, I have read and understand the office guidelines and I agree to honor them.
Parent/Guardian Signature: _____ Date: _____