Lahaina Dental Group

845 Waine`e St, Suite 206, Lahaina, HI 96761
(808) 661-4700
lahainadental@outlook.com

WELCOME TO LAHAINA DENTAL GROUP

Thank You for selecting our dental healthcare Team!
We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (confidential)

Name: _____ Birthdate: _____ SSN: ____-___-____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____ Home Phone:_____

Patient`s sex: ☐ F ☐ M

Do you prefer to receive calls at your: ☐ Cell Phone ☐ Home Phone

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College: _____City:_____State:_____

Patient or Parent/Guardian`s Employer: _____ Work Phone:_____

Business Address:_____ City: _____ State: _____

Zip:_____

Spouse or Parent/Guardian`s Name: _____ Employer:_____ Work Phone:____

Who May We Thank for Referring You? _____

Person to contact in Case of Emergency: _____ Phone:_____

Responsible Party

Name of Person Responsible for this Account: _____

Relationship to Patient: _____

Address:_____ Home Phone: _____

Email: _____ Cell Phone: _____

Driver`s license # _____ Birthdate: _____Financial Institution:_____

Employer: _____ Work Phone:_____ SSN: ____-___-_____

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Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Other CC ☐ I wish to discuss the office`s payment policy.

Insurance Information

Name of Insured: _____Relationship to Patient: _____

Birthdate: _____ SSN: ____-___-____ Date Employed: _____

Name of Employer: _____ Work Phone:_____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address:_____ City: _____ State: _____ Zip: _____

How Much is Your Deductible? _____How Much Have You Used: _____

Max. Annual Benefit: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE ☐ YES ☐ NO If yes, complete the following:

Name of Insured: _____Relationship to Patient: _____

Birthdate: _____ SSN: ____-___-____ Date Employed: _____

Name of Employer: _____ Work Phone:_____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address:_____ City: _____ State: _____ Zip: _____

How Much is Your Deductible? _____ How Much Have You Used: _____

Max. Annual Benefit: _____

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Medical History

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine / Other Narcotics
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs

Check, if applicable

- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia / Leukemia
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia / Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma / Hay Fever
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells / Seizures
- ☐ Y ☐ N Fever Blisters / Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Heart Attack / Stroke
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives / Skin Rash
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning (if known) _____

Last exam date (if known) _____

Date of your last full series x-rays (if known) _____

Date of last cavity detection (bitewing) x-rays (if known) _____

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Do your gums bleed while brushing or flossing?	☐
Are your teeth sensitive to hot, cold or sweets?	☐
Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth?	☐
Have you ever had burning of the tongue or cracking of the corners of your mouth?	☐
Do you chew/smoke tobacco in any form?	☐
Have you had any head, neck or jaw injuries?	☐
Do you notice popping, clicking or soreness of the jaws or points just in front of the ears?	☐
Do you clench or grind your teeth?	☐
Have you ever had orthodontic treatment?	☐
If Yes, date of placement	_____
Do you wear dentures or partials?	☐
If Yes, date of placement of dentures?	_____
Are you happy with your dentures?	☐
Are you having any specific problems with your teeth, gums, or mouth at this time?	☐
Are you happy with your smile?	☐
Do you have problems with teeth/fillings breaking?	☐
Do you regularly use dental floss?	☐
Do you have difficulty in opening your mouth widely?	☐
Do you have an unpleasant taste or odor in your teeth/mouth?	☐
Does food catch between your teeth?	☐
Do you want to learn to control your dental disease and retain your teeth?	☐

Additional Comment: _____

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Medical Questionnaire

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician? ☐

If Yes, what is the condition being treated? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years? ☐

If Yes, what illness or problem? _____

Are you currently taking any medication? ☐

If Yes, what? _____

Have you ever taken the diet control drug Fen-Phen? ☐

Do you use alcoholic beverages? ☐

Do you smoke? ☐

Women Only

Are you pregnant? ☐

If Yes, what is your due date? _____

Are you currently nursing? ☐

Do you have menstrual period problems? ☐

Are you on hormone replacement therapy? ☐

Are you on birth control pills / fertility drugs? ☐

Additional Comments

Any Disease, Condition or Problem not Listed? Please list _____

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Authorization and Release

Full payment is due at the time of treatment. This office accepts HMSA, HDS, Delta Dental, and Cigna dental insurances. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefit otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____

Patient`s/Legal Guardian`s Signature

_____

Date