KIDSHINE PEDIATRIC DENTAL GROUP

Patient Registration Form

Patient (Your Child's) Registration Update

Child's Name ______________________________ Preferred / Nickname ______________

Gender: Male____ Female____ School ______________________________

Date of Birth ______________________ Home Phone ______________________

Address ______________________ City ______________ State ______ Zip ________

Patient's Mother's / Guardian's Information

Name ______________________________ Date of Birth ______________

Social Security Number ______________ Marital Status __________ Occupation ______________

Home Address ______________________ City ______________ State ______ Zip ________

Home Phone ______________ Work Phone ______________ **Cell Phone** ______________

e-mail ______________________________

Patient's Father's / Guardian's Information

Name ______________________________ Date of Birth ______________

Social Security Number ______________ Marital Status __________ Occupation ______________

Home Address ______________________ City ______________ State ______ Zip ________

Home Phone ______________ Work Phone ______________ **Cell Phone** ______________

e-mail ______________________________

Patient's Primary Dental Insurance Information

Subscriber's Name ______________________ Name of Insurance Co. ______________________

ID# ______________ Employer ______________________________

Patient's Secondary Insurance Information

Subscriber's Name ______________________ Name of Insurance Co. ______________________

ID# ______________ Employer ______________________________

Name of Closest Relative ______________________________ **Relationship** ______________

Home Address ______________________________

Home Phone ______________________ Work Phone ______________________

Military Personnel Only: Rank ______________________________

____

Person Responsible for Billing ______________________________ **Relationship** ______________

Billing Address ______________________________

Home Phone ______________________ Work Phone ______________________

Name of Physician ______________________________ **Physician's Phone** ______________

Name of Former Dentist ______________________________ **Date of Last Dental Visit** __________

Whom may we thank for referring you here ______________________________

HEALTH HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

	YES	NO
ANEMIA	____	____
ASTHMA	____	____
CANCER	____	____
HEPATITIS	____	____
HIV / AIDS	____	____
HEMOPHILIA	____	____
ABNORMAL BLEEDING	____	____
ALLERGIES	____	____
ALLERGIES TO PENICILLIN	____	____
ALLERGIES TO ANESTHETIC	____	____

	YES	NO
HANDICAPS / DISABILITIES	____	____
TUBERCULOSIS	____	____
DIABETES	____	____
RHEUMATIC FEVER	____	____
CONGENITAL HEART DEFECT	____	____
HEART MURMUR	____	____
CONVULSIONS / EPILEPSY	____	____

PLEASE EXPLAIN ANY MEDICAL PROBLEMS THAT YOUR CHILD HAS ______________________________

____

____

CHILD'S HABIT

HOW OFTEN DOES YOUR CHILD BRUSH? ______________________________

HOW OFTEN DOES YOUR CHILD FLOSS? ______________________________

DOES YOUR CHILD:

	YES	NO
SUCK THUMB / FINGER	____	____
SUCK / BITE LIPS	____	____
BITE / CHEW NAILS	____	____
CHEW HARD OBJECTS (PENCILS, ETC.)	____	____
GRIND TEETH	____	____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the Dental Office of any changes in my child's medical status.

I also authorize the Dental Staff to perform the necessary dental services my child may need.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN ______________________________ **DATE** __________

I authorized the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to the insurance company to pay directly to the Dentist or Dental Group insurance benefits otherwise payable to me.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN ______________________________ **DATE** __________

Payments of all dental fees is the primary responsibility of the Patient/Parent. All such payments shall be made directly to our Office. We will be happy to assist in preparing the necessary forms to help collect benefits from insurance companies, but it shall be the ultimate and primary responsibility of the Patient/Parent to submit the necessary forms and secure any benefits that may be due.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf on my dependents.

In the event of non-payment from the insurance companies the undersigned agrees to pay all the costs of the dental service rendered.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN ______________________________ **DATE** __________

KIDSHINE PEDIATRIC DENTAL GROUP
DAVID CHING, D.M.D.
LAUREN YOUNG, D.D.S.
TIAN HE, D.M.D.

CONFIDENTIAL

MEDICAL & DENTAL HISTORY

Name__________________________ **Birth Date** __________ **Today's Date** __________

Reason for today's visit: ______________________________

Date of your child's last dental visit: __________ What was done: ______________________________

How many times a day does your child brush? ________ Floss? ________

Does or has your child:	YES	NO		YES	NO
Suck Thumb/Finger	☐	☐	Take Fluoride Supplements	☐	☐
Clench or Grind Their Teeth	☐	☐	Chew Hard Objects (pencils, etc.)	☐	☐
Play any Contact Sports	☐	☐	Had any Head/Neck/Jaw Injuries	☐	☐

Although we primarily treat the area in and around your mouth, any health problems and medications that you may be taking can have an effect on the dental care we provide for you. Thank you for answering the following medical health questions.

	YES	NO		YES	NO
Is your child in good health?	☐	☐	Is your child under the care of a physician now?	☐	☐

Has your child ever been hospitalized since birth?________ If so, why? ______________________________

____

Please list any medications, including non-prescription:______________________________

____

Has your child ever had any of the following:

YES	NO		YES	NO	
☐	☐	Tonsil/Adenoid problems	☐	☐	Cleft Lip and Palate
☐	☐	Heart Disease	☐	☐	Diabetes Type ______________
☐	☐	Congenital Heart Defect / What Type __________	☐	☐	Epilepsy/Seizures/Fainting Spells. How Often______
☐	☐	History of Heart Problems	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Allergies to Antibiotics. List Type __________
☐	☐	Asthma/Hay Fever	☐	☐	Allergies to Anesthetic
☐	☐	Cancer Type ______________	☐	☐	Allergies to Latex
☐	☐	Kidney Disease	☐	☐	Other Allergies ______________
☐	☐	Hepatitis/Jaundice/Liver Disease	☐	☐	Special Needs Type ______________
☐	☐	Aids or HIV Infection	☐	☐	Attention Deficit Disorder/Behavior Problems
☐	☐	Hemophilia Type ______________	☐	☐	Eating Disorder/Problems Feeding
☐	☐	Abnormal Bleeding	☐	☐	Psychological/Emotional Problems
☐	☐	History of Infective Endocarditic	☐	☐	Learning Disability
☐	☐	Any Organ Transplant	☐	☐	Any Type of Abuse
☐	☐	Any Surgeries	☐	☐	Pregnant

Does your child have any disease, condition, or problem not listed above that you think we should be aware of? __________

____

Physician's Name:______________________ Physician's Phone #: ______________________

PLEASE READ CAREFULLY BEFORE SIGNING. IF YOU HAVE QUESTIONS OR DO NOT UNDERSTAND, PLEASE DISCUSS THIS STATEMENT WITH OUR STAFF BEFORE SIGNING.

I certify that I have read, understand and provided the above information to the best of my knowledge. I have answered the questions above as accurately as possible. I understand that providing incorrect information can be dangerous to my child's health. I understand it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Dr. David Ching, Dr. Lauren Young, Dr. Tuan He and staff to gather clinical information, diagnose and perform treatment necessary for my child's dental health care needs.

______________________________ ______________
Signature of Parent/Guardian Date

KidShine Pediatric Dental Group

Pearl City Shopping Center
850 Kamehameha Hwy #215
Pearl City, HI 96782
(808) 638-3313

Kapolei Shopping Center
590 Farrington Hwy #155
Kapolei, HI 96707
(808) 428-8019

CONSENT FORM

Prior to using or disclosing your protected health information to carry out treatment, payment of health care operations, KidShine Pediatric Dental Group is required under federal law to obtain your consent. Please review this consent. If you agree with its terms, please sign and date this consent below. By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment or health care operations. You have the right to request restrictions on how your protected health information is used or disclosed to carry out treatment, payment or health care operations. However, we are not required to agree to such restrictions. If we agree to a restriction that you request, such restriction will be binding. You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I,____(Patient/Guardian), hereby certify that I have read the provisions set forth in this consent.

Signature of Parent/Guardian:_____________________________________ Date:_______________

Print Name:____

Acknowledgement of Receipt of Notice of Privacy Practice

I,_____________________________(parent/guardian) for______________________________(patient) have received a copy of this dental office's Notice of Privacy Practices.

Signature of Parent/Guardian:_____________________________________ Date:_______________

Print Name:____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❏ Individual refused to sign
- ❏ Communication barriers prohibited obtaining the acknowledgement.
- ❏ An emergency situation prevented us from obtaining acknowledgement.
- ❏ Other (please specify).

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Financial Agreement/Cancellation/Missed Appointment Policy

Our goal is to provide quality dental care in a timely manner. See below for our updated financial policies and cancellation/ missed appointment policy, effective 2/4/2021. This policy allows us to better utilize available, appointments for our patients in severe pain needing immediate care.

Financial Agreement:
In our continued commitment to provide the highest quality dental care to you and your family, we are pleased to offer these different forms of payment. We appreciate payment for services at the time they are rendered. Patients who have dental insurance can pay their estimated copayments and deductibles at time of service. Payments may be made with Cash, Check, Visa, Mastercard, Discover, or Amex. There will be a fee of $25 for all returned checks.

Alternative Payment Options:

1. Pay-In-Full Discount: We offer a 5% discount for all services over $300, if paid in full prior to services being rendered.
2. Term Loan: We offer CareCredit, which is a financing option for healthcare expenses. Through CareCredit, we can offer (upon approval) an interest-free term loan for up to 18 months, with no down payment, no annual fee, and no prepayment penalty.

Treatment Plan Estimates:
As a courtesy to our patients, we will provide treatment plan estimates prior to treatment rendered so that you may have an estimate for your patient portion. Please note that treatment plans may change and that it is only an estimate of what your insurance will cover.

Insurance Information:
As a courtesy to our insured patients, we will submit claims to your insurance company on your behalf. In order to help you to receive you maximum benefits allowed, we ask that you provide us with your insurance card and any updated insurance information. Any remaining balance not paid from insurance will be patients responsibility.

Cancellation of an Appointment:
To be respectful of the dental needs of other patients, please be courteous and call the office promptly if you are unable to make your child's/children's appointment. This time will be reallocated to someone who is in urgent need of treatment. If necessary to cancel your scheduled appointment, we require 72 hours in advance.

How to Cancel Your Appointment:
To cancel appointments, please call 808-638-3313 or 808-427-9987 and request to speak to someone in the office your appointment is scheduled in.

No-Show Policy:
A "no-show" is someone who misses an appointment without calling 72 hours in advance to cancel. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show".
Without notice, we charge $50 missed appointment fee & will only schedule on a same day basis.

If patient accumulates 2 no-shows, patient will be released from our office and we will only scheduled your child on an emergency basis for 90 days and assist with finding your child a new dental home.

By signing this agreement, you are agreeing to the terms and conditions specified above.

Parent Name	Parent Signature	Date

DAVID CHING, D.M.D.
LAUREN YOUNG, D.D.S.
TIAN HE, D.M.D.

KIDSHINE PEDIATRIC DENTAL GROUP
PEARL CITY SHOPPING CENTER
850 KAM HIGHWAY, STE. 215
PEARL CITY, HAWAII 96782

TELEPHONE (808) 638-3313

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose you health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose you health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment except for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure for your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Heath-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.________ for each page, $________ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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CELL PHONE AND VIDEO TAPING POLICY

The use of phones, cameras and other recording devices are restricted while treatment is being performed in the operatories.
This includes all teeth cleanings and dental treatments.

We welcome you to take pictures of your child once treatment is completed.

Print Name: ______________________________

Parent/Guardian Signature: ______________________ **Date:** ____________