

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  
 Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party (if someone other than the patient) \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

**Section 3**

CELL PHONE: \_\_\_\_\_

Pager #: \_\_\_\_\_

FAX #: \_\_\_\_\_

ER contact: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: .00 Rem. Deduct: .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: .00 Rem. Deduct: .00

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |                                                                              |                                                                              |                                                                          |                                                                               |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|                                                                              |                                                                              |                                                                          | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No

Comments:

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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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Michael K Sakuda DDS, LLC  
40 Aulike St Suite 214  
Kailua HI, 96734

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT FORM

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations Michael K Sakuda DDS, LLC 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.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a "Notice of Privacy Practices" prior to signing this consent

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 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 restrictions will be binding.

You have the right to revoke this consent in writing, except to the extent that we have taken actions in reliance on your consent.

I, \_\_\_\_\_, hereby certify that I have read/received a copy of this office's Notice of Privacy Practices and that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between you and the office of Michael K Sakuda DDS, LLC. No other individuals/organizations have permission to obtain my confidential information under this consent.

This consent form will be kept in your patient file for a period of six (6) years.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**For Dentist Use Only:**

Signature of Recipient: \_\_\_\_\_

Date Received: \_\_\_\_\_

## Michael K. Sakuda, DDS, LLC

40 Aulike Street, Suite 214

Kailua, Hawaii 96734

### NOTICE OF PRIVACY PRACTICES - HIPAA

THIS NOTICE DESCRIBES HOW YOUR DENTAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

The Health Insurance Portability & Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical, dental records and other individually health information are kept properly confidential. This notice describes how we protect your health information and what rights you have regarding it. Our office uses your health information for treatment, payment and health care operations. Your health information is contained in paper and electronic records that are the property of Michael K. Sakuda DDS, LLC. We are obligated by law to give you notice of our privacy practices effective April 14, 2003.

#### Use or Disclosure of Your Health Information

**For Treatment:** We may use your health information to provide you with dental treatment and services. For example, health information obtained by our office that is related to your treatment will be included in your dental record. This information is necessary so that we may determine what treatment you should receive. We will also record any recommendations or actions taken by our staff in the course of your treatment and note how you respond to these recommendations or actions. We may use this health information when referring you to another doctor for specialty treatment or when we receive copies of your records from another professional you may have seen before us.

**For Payment:** We may use and disclose your health information to others for purpose of receiving payment for treatment and services that you receive. For example, a claim may be sent to your insurance carrier from our office, in order for your insurance carrier to make payment based upon your dental benefits coverage. The information on the claim will include information that identifies you, your diagnosis and treatment and/or supplies used in the course of treatment. We may also use this information in collecting unpaid amounts (directly or through a collection agency or attorney).

**For Health Care Operations:** We may use and disclose health information about you for operational purposes. This means using your information in administrative and managerial functions that we must do in order to run our office. For example, your information may be use or disclosed to:

- Evaluate the performance of our office
- Assess the quality of care and outcomes in your case and similar cases
- Learn how to improve our services to you
- Conduct internal billing or business planning audits

**Appointments:** We may use your information to provide you with verbal or written (including electronic communication) appointment reminders, information about treatment alternatives, or other dental-related benefits and services that may be of interest to you. Unless we are notified in writing otherwise, we may leave you a reminder message on your home or mobile phone answering machine, or with someone who answers your phone if you are not home.

**Required by Law:** We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority
- To report information related to victims of abuse, neglect or domestic violence
- To assist law enforcement officials in their law enforcement duties.

**Public Health:** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

**Decedents:** Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

**Research:** We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

**Health and Safety:** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

**Government Functions:** Your health information may be used for specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of protected health information.

**Workers Compensation:** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

### **Your Health Information Rights**

You have the right to:

- Request a restriction on certain uses or disclosures of your protected health information, however, we are not required to agree to a requested restriction
- Obtain a paper copy of the Notice Of Privacy Practices upon request
- Inspect and obtain a copy of your dental records had by us upon request
- Request to amend your dental records
- Request communications of your dental information by alternative means or at alternative locations
- Revoke your authorization to use or disclose dental information except to the extent that action has already been taken
- Receive an accounting of disclosures made of your information by us

### **Complaints**

You may submit complaints to Dr. Sakuda, your insurance carrier and the the Department of Health and Human Services, Office for Civil Rights if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

### **Obligations of Our Office**

We are required to:

- Maintain the privacy of protected health information
- Provide you with this notice of legal duties and privacy practices with respect to your health information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law

By law, we must abide by the terms of this notice of privacy practices until we choose to change it. We reserve the right to change our privacy practices and to make new provisions effective for all protected health information it maintains. As notices are revised, we will have them posted in our office and have copies available for review.

If you have any questions or complaints, or if you do not want to provide your consent to us to use your protected health information for purposes of treatment, payment and /or health care operations, please submit a letter of denial to provide consent to:

Privacy Officer  
Michael K. Sakuda DDS, LLC  
40 Aulike Street, Suite 214  
Kailua, Hawaii 96734