Thank you for choosing Kona Coast Dental Care for your dental needs. We are committed to providing you with excellent care, unprecedented convenience, and affordable financial options. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read and sign the following.

Payment:

Payment is due in full when scheduling dental treatment. For your convenience we offer several payment options.

- Cash, Visa, MasterCard, American Express, and Discover
- Checks
- Extended payment plans provided through Care Credit and other finance companies

Insurance:

Our office is committed to helping patients maximize their benefits, however insurance policies vary greatly. Therefore, we can only ESTIMATE in good faith, not guarantee payment or coverage from your insurance carrier. Any and all estimated out-of –pocket expenses will be discussed in detail before starting any dental procedures.

Financial Consent:

The patient or guardian agrees to be fully responsible for total payment of treatment performed in this office regardless of reimbursement from Insurance carrier.

I understand and agree to this Financial Policy and Agreement. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kona Coast Dental Care and their Associate Doctors to release any information required to process my claims.

_____ _____

Name of Patient (Please Print) Name of Responsible Party (Please Print)

_____ _____

Signature of Responsible Party Date

PATIENT REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name: First: Middle:			Preferred Name:
❑ Mr. ❑ Mrs. ❑ Ms.	Marital Status (please circle one) Single / Married / Other : _____	Birth Date: ____/____/____	Social Security Number: _____-____-_____
Email Address:			Cell Phone Number: ( )

Address:	City:	State:	Zip code:	Home Phone Number:
Occupation:	Employer:			Employer Phone Number: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:			

Medical History

Are you under a physician's care now?	o No	o Yes
Have you ever been hospitalized or had a major operation?	o No	o Yes
Have you ever had a serious head or neck injury?	o No	o Yes
Do you have sleep apnea?	o No	o Yes
Do you use tobacco?	o No	o Yes

Women Only:

Are you…
___Pregnant
___Trying to get Pregnant
___Nursing
___Taking Oral Contraceptives?

List Medications: _____

Are you allergic to any of the following?
o Aspirin o Penicillin o Codeine o Acrylic o Metal o Latex o Local Anesthetics o Other _____

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

o AIDS/HIV Positive	o Drug Addiction	o Headaches	o Scarlet Fever
o Alzheimer's Disease	o Epilepsy or Seizures	o Heart Condition _____	o Shingles
o Arthritis/Gout	o Excessive Thirst	o Kidney Problems	o Stomach/Intestinal Disease
o Artificial Joint	o Fainting Spells/Dizziness	o Liver Disease	o Sinus Trouble
o Asthma	o Glaucoma	o Lung Disease	o Tumor or Growths
o Cancer	o Hemophilia	o Pain in Jaw Joints	o Parathyroid / Thyroid Disease
o Cold Sores/Fever Blisters	o Hepatitis _____	o Psychiatric Care	
o Diabetes	o High or Low Blood Pressure	o Stroke	

Have you ever had any serious illness not listed above? o Yes o No o N/A _____

_____

In case of Emergency:

Name of Local Friend or Relative (not living in same address): Relationship To Patient: Good Phone Number:

_____ _____ (_____) _____

The above information is true to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

HIPAA Information and Consent

I acknowledge that I have read or have had the opportunity to read Kona Coast Dental Care HIPAA Information Policy. I have also had the opportunity to ask questions about it and understand that I may receive a copy of this at my request. By signing below, I understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signed: _____ Date: _____