Darren Wong, DDS & Kristi Koyanagi, DDS
1060 Young Street, Suite #305
Honolulu, Hawaii 96814
808-528-1200

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name (Last, First, MI):________________ Parent's Name (if minor)________________

Phone Number: ________________ Alternate Phone Number (cell or work): ________________

E-Mail Address: ________________ Best way to contact: Text, phone call, email

Referred by: [ ] Friend/family [ ] Google [ ] Yelp [ ] TikTok Ad. [ ] Other:____________

Home Address:________________________________

Date of Birth: ________________ Age: ______ Sex: M F Social Security Number: ________________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed. Name of Partner ________________

Patient's Employer: ________________

Business Telephone:________________

Employment Status: [ ] Full time [ ] Part time. [ ] Unemployed [ ] Retired [ ] Student [ ] Other: ________________

Emergency Contact: ________________ Relationship to Patient: ________________

Address: ________________ Phone number: ________________

INSURANCE INFORMATION

Primary Insurance: ________________ Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: ________________ Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: ________________ Relationship to Patient: ________________

Address: ________________________________

Social Security Number: ________________

Date of Birth: ________________

His or Her Employer: ________________ Work Phone Number: ________________

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s):________________ Relationship to Patient: ________________

MEDICAL AND DENTAL HISTORY

Physician: ______________________ Telephone: ______________________ Last Visit: __________

This information is CONFIDENTIAL and will not be released without your permission.

Do you have or have you ever had any of the following conditions?

Yes	No	
☐	☐	High blood pressure = ____/____
☐	☐	Heart murmur (rheumatic fever/MVP)
☐	☐	Artificial heart valve
☐	☐	Pacemaker
☐	☐	Stroke
☐	☐	Asthma/bronchitis/emphysema
☐	☐	Sinusitis
☐	☐	Ear problems
☐	☐	Cold sores/canker sores/herpes
☐	☐	Jaundice/liver problems
☐	☐	Thyroid problems
☐	☐	Diabetes

Yes	No	
☐	☐	Epilepsy
☐	☐	Kidney infection/disease
☐	☐	Anemia
☐	☐	Bleeding problems/bruise easily
☐	☐	Stomach ulcers/gastritis
☐	☐	Cancer: (chemotherapy/radiation)
☐	☐	Eye problems/contact lens/Glaucoma
☐	☐	Chewing/bite problems
☐	☐	Headaches/jaw problems
☐	☐	Gum problems
☐	☐	Oral habits: __________
☐	☐	Hospitalized/had major surgery __________

Have you ever tested positive for:

Yes	No	
☐	☐	Venereal disease
☐	☐	Hepatitis (A or B)
☐	☐	Tuberculosis (TB)
☐	☐	Human Immune Deficiency Virus (HIV)
☐	☐	Have you ever had a blood product transfusion?
☐	☐	Do you have any implants or artificial prosthesis/joints?

Yes	No	
☐	☐	Are you currently or have you ever been under psychiatric care/counselling?
☐	☐	Are you currently pregnant or breast feeding?
☐	☐	Do you smoke/chew tobacco?
☐	☐	Recent weight change greater than 10 pounds?
☐	☐	Have you ever failed to undergo recommended dental treatment?
☐	☐	Tonsils/adenoids removed?

ALLERGIES: Do any of these cause illness, rash, stomach upset?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetic	☐	☐	Adhesive tape	☐	☐	Narcotics	☐	☐	Sleeping pill
☐	☐	Antibiotics	☐	☐	Iodine	☐	☐	Codeine	☐	☐	Other: __________
☐	☐	Aspirin	☐	☐	Cortisone/steroid	☐	☐	Sedatives			__________

MEDICATIONS that you are currently taking or have been prescribed for you:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Antibiotics	☐	☐	Blood thinner/anti-coag.	☐	☐	Antihis./Decongest/	☐	☐	Other: __________
☐	☐	Blood pressure pills	☐	☐	Birth control/hormone	☐	☐	Sedative/Tranquilizers			__________
☐	☐	Aspirin/Arthritis pill	☐	☐	Thyroid pills	☐	☐	Heart pills			__________
☐	☐	Insulin/Diabetes pill	☐	☐	Cortisone/steroid	☐	☐	Narcotics/Pain pills			__________

Reason for this dental visit: __________

Last dental visit? __________ What was done? __________

WARNING: For patients taking **birth control pills**, Some antibiotic medications reduce the effectiveness of birth control pills, so an alternate method of birth control should be utilized while taking antibiotics for infection.

I hereby authorize Dr. Chang and staff to perform an examination, take radiographs, oral impressions, and photographs, and to communicate and disclose the above information with the above physician as it relates to my health care. The above information is complete and true to the best of my knowledge.

Signature of patient or guardian __________ Date __________ Interviewer __________

DentaWorks Hawaii

1060 Young St. #305

Honolulu, HI 96814

(808)528-1200

Consent for Disclosure of Health Information and

Receipt of Notice of Privacy Practices

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, DentaWorks Hawaii 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.

Should you desire a more complete description for the permissible uses and disclosure of your protected Health information, you have the right to review a Notice of Privacy Practices (The "Notice") 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 how your protected Health information is used and disclosed to carry out treatment, payment or health operations. However, we are not required to agree to such restrictions. If we agree to restrictions that you request, such restrictions are 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________________________________(name of patient), hereby certify 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 (patient) and DentaWorks Hawaii. No other individuals/organizations have permission to obtain my confidential information under this consent.

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

____ Date:______________

Signature

____

Print Name

DentaWorks Hawaii

1060 Young St. #305

Honolulu, HI 96814

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Cancelled and Failed Appointment Policy

DentaWorks Hawaii is committed to providing our patients with quality dental care. We realize the importance of your time and will do everything possible to not keep you waiting. We ask that you respect our time as well and arrive on time for your scheduled appointments. Your appointment time is reserved for you and only you. We do not double book or overbook appointments.

Due to patients who schedule then do not show for their appointments, we have instituted a **Failed Appointment Fee of $75**. Insurance does not cover this fee. This fee must be paid prior to your next scheduled appointment.

We understand that situations do arise in which you must change an appointment. Proper notice for cancelled appointments must be given to our office in order to serve all of our patients. When given proper notice, we are able to contact patients who are trying to get an appointment in our office.

It is your responsibility to write down and keep track of your scheduled appointments. Appointment reminders are only a courtesy. We will text your cell phone one week prior to your appointment. Your response to our text is important. We will continue to contact you until we get a response. If you cannot receive text message, we will call you on your landline and will leave you a message. Please call us back to confirm your appointment.

We must receive your cancellation no less than 48 hours prior to your scheduled appointment. Messages left on our answering machine after hours, canceling an appointment with less than 48 hours or over the weekend are not acceptable.

I________________________________have read the Cancellation and Failed Appointment Policy. I understand that I will be charged $75 for any failed appointment in which 48 hours notice is not given.

____________________________________ Date:________________

Signature:

Updated 4/5/2022

COVID-19 PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have **experienced any signs or symptoms associated with the COVID-19 virus especially after being seen in our office within 3 days of your appointment.**

	Yes	No
Have you completed COVID-19 vaccine?		
Are you having any COVID-19 symptoms?		
Have you recently lost or had a reduction in your sense of smell?		
Have you been exposed to COVID-19 positive within the last 10 days?		
Have you been asked to quarantine?		

I fully understand and acknowledge the above information, risks and cautions regarding a comprised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_______________________________ _________________

Signature Date

_______________________________ Temp: ________ O2: ________

Print Name (to be taken by staff)

COVID-19 VACCINE: MODERNA PFIZER J&J

1ST DOSE: ___________ 2ND DOSE: ___________ BOOSTER: ________, __________

For future visits only.

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Any changes? YES NO Initial: _______ Date: _______ Temp: _______ O2: _______

Updated(07/21/22)