Leong Family Dental

2885 Pa'a Street Suite #203
Honolulu, Hawaii 96819

1020 Kakala Street Suite #801
Kapolei, Hawaii 96707

PATIENT INFORMATION

Date _____SS/HIC/Patient ID #_____

Last Name_____First Name_____Middle Intl_____

Address_____

City_____ State_____ Zip_____

Email_____ Sex □ M □ F Birthdate_____ Age _____

□ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered Patient

Employer_____ _____ Occupation_____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home(___) _____ Work(___) _____ Ext _____ Cell Phone (___)_____

IN CASE OF EMERGENCY, CONTACT: Name_____Relationship_____

Home(___) _____ Work(___) _____ Ext _____ Cell Phone (___)_____

DENTAL INSURANCE

Subscriber's Name _____ Relationship to patient_____

Sub. Birthdate _____ Sub. SS# _____ Insurance Co. _____

Group# _____ Subscriber ID #_____ Dual insurance? □ Yes □ No

Subscriber's Name _____ Relationship to patient_____

Sub. Birthdate _____ Sub. SS# _____ Insurance Co. _____

Group# _____ Subscriber ID #_____

BILLING PREFERENCE

□ Email □ Mail

Assignment and Release I certify that I, and/ or my dependent(s), have insurance coverage with _____and assign directly to Name of insurance company Dr. Kyle K. Leong DDS all insurance benefits, If Any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance companies and their agents pose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of patient/parent/guardian Date Relationship to patient

Continue to next page ⟶

DENTAL HISTORY

Reason for today's visit _____ Former Dentist _____

Date of Last Dental Visit _____ Date of Last x-rays _____

Place indicate if you have the following:

	Burning sensation on tongue		Mouth breathing
	Chew on 1 side only		Blister on lips
	Smoking		Ortho treatment
	Clicking or popping of jaw		Pain around ears
	Dry Mouth		Periodontal treatment
	Fingernail biting		Sensitivity to cold
	Food collecting between teeth		Sensitivity to heat
	Foreign Objects		Sensitivity to sweets
	Grinding teeth		Sensitivity to biting
	Gums swollen or tender		Sores or growths in mouth
	Bad breathe		Jaw pain or tiredness
	Bleeding gums		

How often do you floss (day) _____ How often do you brush (a day) _____

HEALTH HISTORY

Physician's Name _____Date of last visit _____

** Have you ever taken any of the group of drugs collectively referred to as "Fen-phen?" These include combinations of Lonimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) □ Yes □ No

****Place a mark (X) to indicate if you have or had any of the following:**

	ADHD		Dialysis		Mitral Valve Prolapse		Weight Loss - Unexplained
	AIDS / HIV		Dizziness		Nervous Problems		Other :
	Anemia		Emphysema		Pacemaker		
	Arthritis –Type _____		Epilepsy		Psychiatric Care		
	Artificial Heart Valves		Excessive bleeding		Radiation Treatment		
	Artificial Joints		Fainting		Respiratory Disease		
	Asthma		Glaucoma		Rheumatic Fever		**NONE**
	Autism		Headaches		Scarlet Fever		
	Back Problems		Heart Murmurs		Shortness of breath		
	Blood Disease		Heart Problems		Sinus Trouble		
	Cancer		Hepatitis Type _____		Stroke		
	Chemical Dependency		Herpes		Swollen Feet or Ankles		
	Chemotherapy		High Cholesterol		Swollen Neck Glands		
	Circulatory Problems		High Blood Pressure		Thyroid Problems		
	Congenital Heart Lesions		Jaundice		Tonsillitis		
	Cortisone Treatments		Jaw pain		Tumor on head or neck		
	Cough, chronic/bloody		Kidney Disease		Ulcer		
	Diabetes		Low Blood Pressure		Venereal Disease		

Women: Taking birth control pills YES/NO? Are you pregnant? YES/NO Due date:_____ Are You Nursing?_____

Medications:

List any medications and reason for taking:

_____

_____

Drug Allergies:

_____ Aspirin _____ Barbiturates _____ Codeine

_____ Iodine _____ Local Anesthesia _____ Penicillin

_____ Sulfa _____ Other _____

Leong Family Dental

2885 Pa'a St. #203
Honolulu, Hawaii 96819

1020 Kakala St. #801
Kapolei, Hawaii 96707

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers, (insurance carries, etc.)

*Conduct normal healthcare operations

I have received, read and understand this Notice of Privacy Practices containing a more complete description of the uses and discloses of my health information, I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

_____

Print Patient Name(s) Print Name of Guardian Relationship

_____

Signature Date

Official Use Only

_____

Print Name and Initial Date

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (specify) _____

Continue to next page ⟶

Leong Family Dental

Office Policy

Honolulu Office Hours

Monday	7:00am-5:00pm
Tuesday	7:00am-5:00pm
Wednesday	7:00am-5:00pm
Thursday	7:00am-5:00pm
Friday	7:00am-5:00pm
Saturday	7:30am-1:00pm
Sunday	Closed

Kapolei Office Hours

Monday	8:00am-4:00pm
Tuesday	8:00am-4:00pm
Wednesday	8:00am-4:00pm
Thursday	8:00am-4:00pm
Friday	Closed
Saturday	7:30am-1:00pm
Sunday	Closed

Appointment and Cancellation Policy

If you are unable to keep an appointment, please give us a 24-hour notice to prevent a $25.00 charge.

Despite careful scheduling, emergencies can cause delays. We try our very best to stay on time. If your appointment is affected due to a unforeseen emergency, we'll try to notify you. We know that your time is valuable too. You will receive the same quality dental care n matter how our schedule is running.

Fees and Payment Options

We base our fees on quality, expertise, time and service. We give treatment estimates before doing any dental work to ensure that you are aware of what the charges are. Please keep in mind that these are just estimates and actual costs will be determined once claim has been submitted and processed to your insurance company. To make payment more convenient for you, we accept case, check, Visa, MasterCard and Carecredit. We also offer payment arrangements. If account is 90 days delinquent after the first statement has been sent and no payment arrangement has been made, your account will automatically be sent to a collection agency.

Dental Insurance

Many of our patients have dental insurance. While your dental insurance is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that most dental insurance companies do NOT pay 100% for all treatment. Payment to our office is your responsibility, regardless of how your insurance company does or does not pay. For extensive treatments, most insurance companies require pretreatment estimates.

Print Patient Name(s)

Signature Date