Patient Information

PATIENT LAST NAME FIRST MIDDLE	PREFERRED NAME	DATE OF BIRTH	☐ MALE ☐ FEMALE
SOCIAL SECURITY #	HOME PHONE	CELL PHONE	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP
ADDRESS APT. #	CITY	STATE	ZIP CODE
EMAIL	CAN WE TEXT YOU TO CONFIRM YOUR APPOINTMENT	Y	N
EMERGENCY CONTACT	RELATIONSHIP	PHONE ( )	ADDRESS
GENERAL DENTIST	PHONE	PRIMARY CARE PHYSICIAN	PHONE

Responsible Party Information

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE	RELATIONSHIP		
HOME PHONE ☐SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS ☐SAME AS ABOVE	CITY	STATE	ZIP CODE
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION

Primary Dental Insurance

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

Secondary Dental Insurance

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

If a procedure requires multiple appointments, payment is required in full at the first appointment. Payment options include cash, check, all major credit cards and Care Credit.

If the patient has dental insurance coverage, the patient is responsible for the COPAY, ESTIMATED non-covered procedures, and/or deductibles at the time of service. Any remaining balance not covered by the insurance company is the patient's responsibility.

If patient is a minor and will be unaccompanied by the responsible party, prior arrangements must be made for payment. An annual interest of 18% will be charged for any and all unpaid balances and a $15 non-payment fee may be assessed. There will be a $30 processing charge added to your account for all returned checks.

I, _____, hereby confirm that the above information is correct. I also agree to and fully understand the financial terms as listed above.

Signature _____ Date _____

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Dr. Jeremy Hannon DMD

Telephone: (808)230-8000

Address: Oahu Oral and Maxillofacial Surgery LLC
45-1144 Kamehameha Hwy
Suite # 301
Kaneohe, HI 96744

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other Please Specify: