

**Island Dentistry Inc.**  
**30 Aulike Street, Suite 503 Kailua, HI 96734**  
**261-1446 IslandDentistryInc.com**

**Patient Information:**

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Sex \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

**Responsible Party Information:**

Full Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Dental Insurance Information**

Primary Insurance  
Subscriber Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Address \_\_\_\_\_ Phone \_\_\_\_\_  
Secondary Insurance  
Subscriber Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Address \_\_\_\_\_ Phone \_\_\_\_\_

**Medical Information:**

Are you having pain or discomfort at this time? \_\_\_\_\_ Where \_\_\_\_\_  
Name of last dentist \_\_\_\_\_ Reason for leaving \_\_\_\_\_  
When was your last dental visit? \_\_\_\_\_ Date of last x-rays taken \_\_\_\_\_  
How does the patient receive fluoride? \_\_\_\_\_  
How would the patient like to improve his/her teeth? \_\_\_\_\_  
If child patient, who brushes the child's teeth? \_\_\_\_\_  
Does the patient have a medical health problem? Please explain \_\_\_\_\_  
Is the patient under the care of a physician? Please list name and phone# \_\_\_\_\_  
Does the patient take any medications? Please list \_\_\_\_\_  
Does the patient have any allergies to medications, latex, anesthetics, etc? Please list \_\_\_\_\_

Does the patient have any serious illnesses or surgeries? Please list \_\_\_\_\_

Does the patient have a heart murmur or other heart conditions? Explain \_\_\_\_\_

Has the patient ever experienced prolonged or abnormal bleeding? \_\_\_\_\_

Does the patient have AIDS or been tested positive for HIV? If yes, when? \_\_\_\_\_

Does the patient have asthma or other respiratory problems? \_\_\_\_\_

Does the patient have a nervous disorder, experience fainting or seizures? Explain \_\_\_\_\_

What is the main purpose of today's visit? \_\_\_\_\_

**Please circle if the patient has experienced any of these conditions:**

DIABETES	CEREBRAL PALSY	AUTISM
HIGH BLOOD PRESSURE	RHEUMATIC FEVER	CANCER
CONGENITAL BIRTH DEFECTS	HEPATITIS	EPILEPSY
KIDNEY INFECTION	LIVER DYSFUNCTION	
DEVELOPMENTAL/LEARNING PROBLEMS	EYE/SPEECH/HEARING PROBLEMS	

**ACKNOWLEDGEMENT OF HIPAA PRIVACY ACT, CANCELLATION AND FINANCIAL POLICIES:**

I, \_\_\_\_\_, acknowledge that I have been given the opportunity to read/obtain a Notice of Privacy Practices from Island Dentistry Inc. I authorize Dr. Lilly Geyer to perform diagnostic procedures and treatment as may be necessary for proper dental care and authorize office staff to review information in my/my child's chart as needed. I authorize release of any information concerning health care, advice and treatment provided for the purpose of evaluating and administrating claims for dental benefits, and to call or mail notification to me regarding treatment. I authorize Island Dentistry to take and post pictures of me and/or my family within the office or on their website for advertising purposes only.

I agree to give at least 2 business days notice to cancel or change an appointment. I understand a \$35.00 missed appointment fee will be charged per appointment without 48 business hours notice. If I cancel/miss more than 2 appointments in a 12 month period without appropriate notice, I understand Island Dentistry has a right to dismiss me/my family from the practice.

I hereby authorize payment of insurance benefits to be paid directly to Island Dentistry/Dr. Lilly Geyer, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for all treatment rendered. I understand that Island Dentistry will bill my insurance for me but if payment has not been received after 90 days, I will be responsible for the full amount. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care insurance.

**I CERTIFY THAT THE ABOVE IS COMPLETE AND ACCURATE:**

SIGNATURE (if patient is a minor, signature of parent/guardian) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ DATE \_\_\_\_\_

Doctor Signature \_\_\_\_\_ DATE \_\_\_\_\_

**PAYMENT OPTIONS AVAILABLE FOR ISLAND DENTISTRY:**

Payment can be made by Cash, Check, Visa, MasterCard, American Express or Discover Card

A 5% courtesy discount is applied if your portion is \$1000 or more when entire amount is paid by cash/prior to starting treatment.

We also offer a NO INTEREST payment plan from care credit (O.A.C.)

Island Dentistry requires payment of copays prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

Island Dentistry Inc. charges \$30.00 for returned checks.