

**Kaimuki Dental Group**  
3221 Waiialae Avenue  
Suite 315  
Honolulu, HI 96816  
kdgroup888@gmail.com  
(808) 737-7905

Mendel I. Sato, D.M.D.  
Westley T. Sato, D.D.S.  
Bryan I. Sato, D.D.S.  
Jaci A. Young, D.D.S  
Brenda T.L. Huynh, D.D.S

**PATIENT INFORMATION**

**DATE** \_\_\_\_\_

Patient's name (Last, First, M.I.): \_\_\_\_\_ [ ] Male [ ] Female

**Address:** Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Referred By: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)**

Patient's name (Last, First, M.I.): \_\_\_\_\_ [ ] Male [ ] Female

**Address:** Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Soc. Sec #: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**AUTHORIZATION**

I hereby grant permission to the attending dentist to perform all procedures and diagnostic tests deemed necessary for therapeutic treatment of lesions associated with the oral cavity. These accepted techniques may include x-rays, the administration of medicines, anesthetics, and dental surgical procedures.

\*if patient is a minor, all forms must be completed by the parent or guardian before active treatment is initiated. (Please state the relationship to the child)

Authorization (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship (if minor): \_\_\_\_\_

**PRIMARY DENTAL INSURANCE COMPANY**

HDS / HMSA / HMAA / OTHER \_\_\_\_\_

Policy holder name: \_\_\_\_\_

Birthdate \_\_\_ / \_\_\_ / \_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_

Membership/Group # \_\_\_\_\_

Effective Date \_\_\_\_\_

**SECONDARY DENTAL INSURANCE COMPANY**

HDS / HMSA / HMAA / OTHER \_\_\_\_\_

Policy holder name: \_\_\_\_\_

Birthdate \_\_\_ / \_\_\_ / \_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_

Membership/Group # \_\_\_\_\_

Effective Date \_\_\_\_\_

**PATIENT DENTAL HISTORY**

Patient's name (Last, First, M.I.): \_\_\_\_\_

Chief Oral Complaint: \_\_\_\_\_

How do you feel about dental treatment? (Circle one)      Relaxed      A little uneasy      Tense      Anxious      Very anxious

**Are you troubled by:**

- Teeth sensitive to hot and/or cold
- Teeth sensitive to sweets or pressure
- Bleeding gums
- Food impaction
- Clenching or grinding
- Burning of tongue
- Swelling or lumps in mouth
- Frequent blisters on lips or mouth
- Loosening of teeth
- Bad breath/unpleasant taste
- Mouth breathing
- Oral habit: fingernail biting
- Chronic headaches, neck, shoulder pain

**Have you ever experienced any of the following problems in your jaw?**

- Clicking, unusual sounds while eating
- Pain (joint, ear, side of face)
- Difficulty in opening or closing

**Have you ever had:**

- Difficult extractions
- Prolonged bleeding following extractions
- Orthodontic treatment
- Periodontal treatment (gums)
- Endodontic treatment (root canals)

**Have you ever had instructions on the correct method of brushing your teeth?** [ ] Y [ ] N

**Have you ever had any serious trouble associated with previous dental treatment?** [ ] Y [ ] N

Please indicate:

Texture of toothbrush: \_\_\_\_\_

Frequency of brushing: \_\_\_\_\_

Do you use:

Dental Floss [ ] Y [ ] N

Fluoride Supplements [ ] Y [ ] N

InterDental Stimulators [ ] Y [ ] N

Water Jet Device [ ] Y [ ] N

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental case to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits for payments of all services rendered on my behalf or my dependents.

x \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient or parent/guardian of minor

**TO BE COMPLETED BY DENTIST**

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

---



---



---



---



---



---



---

**PATIENT MEDICAL HISTORY** \*The following questions are for our information only and will be considered confidential.

Patient's Name (Last, First, M.I.): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

	YES	NO		YES	NO
Has there been any change in your general health within the past year?	[ ]	[ ]	Are you allergic to or have you had any reactions to the following?		
Are you under medical treatment?	[ ]	[ ]	- Local Anesthetics (e.g. Novocain)	[ ]	[ ]
Have you ever been hospitalized for any surgical operation or serious illness?	[ ]	[ ]	- Penicillin or other Antibiotics	[ ]	[ ]
Are you taking any medications (including non-prescription medicine)?	[ ]	[ ]	- Sulfa Drugs	[ ]	[ ]
If yes to any of the above, please explain:	[ ]	[ ]	- Barbiturates or Sedatives	[ ]	[ ]
_____			- Sleeping Pills	[ ]	[ ]
_____			- Codeine or other Narcotics	[ ]	[ ]
_____			- Iodine	[ ]	[ ]
			- Aspirin	[ ]	[ ]
			- Other _____	[ ]	[ ]
Do you use tobacco?	[ ]	[ ]	<b>Women only:</b>		
Do you use alcohol?	[ ]	[ ]	- Are you or do you think you may be pregnant?	[ ]	[ ]
Do you use cocaine or other drugs?	[ ]	[ ]	- Are you nursing?	[ ]	[ ]
Are you wearing contact lenses?	[ ]	[ ]	- Are you taking birth control pills?	[ ]	[ ]

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Heart Trouble or Disease  | <input type="checkbox"/> Persistent Swollen Glands |
| <input type="checkbox"/> Heart Attack/Stroke   | <input type="checkbox"/> Cardiac Pacemaker         | <input type="checkbox"/> Sinus Trouble             |
| <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Inborn Heart Defect       |
| <input type="checkbox"/> Immune System Deficit | <input type="checkbox"/> Swollen Ankles            | <input type="checkbox"/> Angina                    |
| <input type="checkbox"/> Fainting/Seizures     | <input type="checkbox"/> Frequently Tired          | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Radiation Therapy         |
| <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Glaucoma                  |
| <input type="checkbox"/> Epilepsy/Convulsions  | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Recent Weight Loss        |
| <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Liver Disease             |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Joint Replacement/Implant | <input type="checkbox"/> Persistent Cough          |
| <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Hepatitis/Jaundice        | <input type="checkbox"/> Abnormal Bleeding         |
| <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> STDs                      | <input type="checkbox"/> Mental Health Problems    |
| <input type="checkbox"/> Thyroid Problem       | <input type="checkbox"/> Stomach Trouble/Ulcer     |  |

Do you have any disease, condition, or problem not listed above that we should know about? [ ] Yes [ ] No

If yes, please explain: \_\_\_\_\_

Signature of Patient (Parent or Guardian if minor): \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY DENTIST**

MEDICAL HISTORY UPDATE

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

---



---



---



---



---

KAIMUKI DENTAL GROUP, LLP  
3221 Waialae Ave., Suite 315  
Honolulu, HI 96816

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

Kaimuki Dental Group uses health information about you for treatment, payment, and health care operations. Your health information is contained in paper and electronic records that are the property of Kaimuki Dental Group. Prior to using or disclosing your protected health information to provide treatment, carry out health care operations, or obtain payment, Kaimuki Dental Group is required under federal law to obtain your consent.

You have the right to request restrictions on how your protected health information is used or disclosed to provide treatment, carry out health care operations, and obtain payment. However, we are not required to agree to such restrictions.

By signing this consent, you agree that we may use or disclose your protected health information to provide treatment, carry out health care operations, and obtain payment.

I, \_\_\_\_\_ (name of patient), hereby certify that I have read and understand this dental office's Notice of Privacy Practices and the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between me (including the children/dependent minors listed below) and Kaimuki Dental Group.

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

\_\_\_\_\_  
Signature of Patient (Parent or Guardian if Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient (Parent or Guardian if Minor)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Print Name(s) of Children/Dependent Minors

**For Dentist Use Only**

Date Received: \_\_\_\_\_

Signature of Recipient: \_\_\_\_\_