Mālama I Ke Ola Health Center Dental Services
1881 Nani St., Wailuku, HI 96793
808-872-4005

Date: _____
Chart #: _____
(For Official Use Only)

Patient Information

Patient Name: _____ **Date of Birth:** _____
Last First MI

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Contact Information: Home: _____ Cell: _____ Email: _____

Veteran: ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Preferred method of contact: ❑ Home Phone ❑ Cell Phone ❑ E-mail

Language Spoken: _____

The clinic receives funding from the Federal Government and we are required to ask you to complete the following information. The information is confidential and will become part of your medical record and may assist your provider in caring for you.

Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Other ❑ Choose not to disclose

Sexual Orientation: ❑ Lesbian/Gay ❑ Straight (not lesbian or gay) ❑ Bisexual ❑ Something Else ❑ Do not know
❑ Choose not to Disclose

Race: (Please check no more than 2)

❑ American Indian/Alaska Native
❑ Asian
  ❑ *Chinese* ❑ *Filipino* ❑ *Japanese* ❑ *Korean* ❑ *Laotian* ❑ *Vietnamese*
❑ Black/African American
❑ Native Hawaiian (Hawaiian, Part-Hawaiian)
❑ Other Pacific Islander
  ❑ *Marshallese* ❑ *Micronesian* ❑ *Samoan* ❑ *Tongan*
❑ White
❑ Multiracial
❑ Patient Refused

Ethnicity: (Please check 1): ❑ Hispanic/Latino ❑ Not Hispanic ❑Patient Declined ❑ Other or Undetermined ❑ Unspecified

Financial Information

You may qualify for discounted services

Number of people in your household: _____ **Gross monthly family income:** **$** _____

Homeless ❑ Yes ❑ No

If yes, please check one: ❑ Shelter ❑ Transitional ❑ Doubling up ❑ Street ❑ Other: _____

Insurance Information

(Present Insurance card(s) to receptionist)

Do you have medical insurance? ❑ Yes *(complete insurance information below)* ❑ No*)*

Primary: Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name: _____

Subscriber's ID#: _____

Do you have other (secondary) insurance coverage? ❑ Yes ❑ No

Insurance Plan Name: _____

Subscriber's ID#: _____

Responsible Party Information

Guarantor Name: _____ **Date of Birth:** _____
Last First MI

Address: _____
Street City State Zip Code

Phone: _____ ❑ Home ❑ Work ❑ Cell

Relationship to patient: ❑ Spouse ❑ Child ❑ Other _____

Emergency Contact Information

Contact Name: _____ **Phone:** _____
Last First MI ❑ Home ❑ Work ❑ Cell

Relationship to patient: ❑ Spouse ❑ Child ❑ Other _____

PAYMENT POLICY

Payment is expected at the time of visit. Please identify which option is your choice for payment:

- ❑ I will make payment at each visit.
- ❑ I will use my medical insurance and pay the co-payment, should there be one, at the time of visit.

ASSIGNMENT OF BENEFITS

I assign my insurance benefits to the Mālama I Ke Ola Health Center. I understand that this assignment is valid for one year unless I cancel authorizations through written notice to the Mālama I Ke Ola Health Center.

AUTHORIZATION TO TREAT

I hereby authorize the medical staff of the Mālama I Ke Ola Health Center, to perform any and all diagnoses, procedures, and/or treatment as deemed necessary for the care and treatment of the patient for the condition for which I or members of my family have sought medical care. This authorization is effective today and will remain in effect until: the guardian/parent releases the patient from our care; the physician withdraws from care; or the patient releases him or herself from our care.

I understand that receipt of services is voluntary. The acceptance of family planning services if requested or provided is not a pre-requisite to eligibility for, or receipt, of any other services.

CONFIDENTIALITY/RELEASE OF MEDICAL RECORDS

Confidentiality/Protected Health Information: All patient health information is confidential unless the information is permitted or required to use or disclosed related to the following circumstances: treatment, payment, health care operations, research, organ and tissue donation, as required by law, to avert serious threat to health or safety, military and Veteran's services, Worker's Compensation, public health issues, health oversight, law enforcement, coroners, health examiners, funeral directors, National Security and Intelligence Activities and inmates. Patients may give or be asked to give authorization for release of information under other circumstances.

ACKNOWLEDGEMENT

I have read the above and I have received or been offered a copy of Mālama I Ke Ola Health Centers' policies for the following:

* Notice of Privacy Practices.
* Patient Rights and Responsibilities.
* Your Advance Directive for Future Health Care pamphlet.

Signed: _____ Date: _____

FOR STAFF USE ONLY

I have received the following documents:

- ❑ Copy of insurance card received
- ❑ Proof of Income received
- ❑ QUEST application given

Employee Initials: _____