HOSHINO
ENDODONTICS

PATIENT INFORMATION

First Name_____ M.I._____ Last Name_____

Gender_____ Birthdate_____ SS #_____ Marital Status _____

Home Address_____

Mailing Address (if different)_____

Home Phone_____ Mobile Phone_____ Email_____

Preferred Method of Contact (please check) Phone_____ Text_____ Email_____

Employer_____ Work Phone_____

Referring Dentist_____ Date of Last Dental Exam_____

Emergency Contact_____ Phone_____ Relationship_____

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible (if self, skip this section)_____

Relationship_____ Birthdate_____ SS #_____ Marital Status_____

Mailing Address_____

Home Phone_____ Mobile Phone_____ Email_____

Employer_____ Work Phone_____

INSURANCE INFORMATION

Primary Insurance_____ ID #_____ Group #_____

Subscriber Name_____ Birthdate_____ Relationship_____

Secondary Insurance_____ ID #_____ Group #_____

Subscriber Name_____ Birthdate_____ Relationship_____

MEDICAL HISTORY

Physician_____ Date of Last Medical Exam_____

Height _____ Weight _____

Yes	No		Yes	No	
___	___	Congenital Heart Disease	___	___	Diabetes
___	___	Heart Murmur/Valve Defect	___	___	Thyroid Disease
___	___	Artificial Heart Valve	___	___	Kidney Disease
___	___	Infective Endocarditis	___	___	Hepatitis/Liver Disease
___	___	Chest Pain	___	___	HIV/AIDS
___	___	Heart Attack	___	___	Acid Reflux/Stomach Ulcer
___	___	Pacemaker	___	___	Cancer
___	___	Stroke	___	___	Chemotherapy/Radiation
___	___	High Blood Pressure	___	___	Joint Replacement
___	___	Tuberculosis	___	___	Osteoporosis
___	___	Asthma	___	___	Bleeding Disorder
___	___	COPD	___	___	Psychological Disorder
___	___	Sinus Problems	___	___	Substance Abuse
___	___	Fainting Spells	___	___	Suppressed Immune System Due to Disease/Drug/Transplant
___	___	Epilepsy			

Do you have any other medical conditions?_____

Are you required to take antibiotics prior to dental treatment?_____

Are you taking bisphosphonates (i.e., Reclast, Fosamax, Actonel, Boniva)?_____

Are you allergic to any food, medications, and/or latex?_____

Please list all current medications you are taking_____

_____

WOMEN ONLY

Are you pregnant or nursing?_____

(Note: Antibiotics may alter the effectiveness of birth control pills. Please consult with your physician/ gynecologist for assistance regarding additional methods of birth control.)

Signature of Patient (Parent/Guardian if Minor)_____ Date_____

CONSENT FOR ENDODONTIC THERAPY

Please take a moment to carefully read our consent form. It explains endodontic (root canal) therapy, including some of the risks and complications that can occur. We ask that you sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

1) I understand that endodontic therapy is a procedure to save a tooth rather than to remove it. It involves making an opening in the tooth or existing restoration to remove damaged soft tissue or infected root canal filling material. The space occupied by this tissue or filling is then cleaned, disinfected, and permanently sealed.

2) I understand that endodontic therapy has a high degree of clinical success. However, as with any medical or dental procedures, no guarantee or warranty of success for any length of time can be given.

3) I understand that there are risks and complications that can occur during or after endodontic therapy, some of which can result in additional corrective treatment, premature tooth loss, or extraction. Possible risks and complications include, but are not limited to, the following:

a) Damage to existing filling, veneer, crown, or bridge
b) Instrument separation within the root canal or perforation of the root canal
c) Fracture of the root or crown of the tooth, during or after treatment
d) Overextension of the filling material used to permanently seal the root canal
e) Blocked canal from prior root canal treatment, natural calcification, or curved root
f) Pain or discomfort for which medication will be prescribed if deemed necessary
g) Swelling or discoloration of the adjacent soft or hard tissue
h) Trismus (restrictive jaw opening) which may last a few days or longer
i) Prolonged or permanent numbness from an injection

4) I understand that proper restoration (filling or filling and crown) of the tooth after endodontic therapy is a necessity. The fee for endodontic therapy does not include restorative procedures. It is my responsibility to have the appropriate restoration placed after endodontic therapy.

5) I understand that I am free to withdraw my consent and discontinue endodontic therapy at any time. Other treatment choices include no treatment, waiting for more definitive development of symptoms, or tooth extraction. However, the risks and complications involved in these choices may include pain, infection, swelling, tooth loss, or spread of infection to other areas.

Signature of Patient (Parent/Guardian if Minor)_____ Date_____

FINANCIAL POLICY

All professional services rendered are charged to the patient. If the patient is a minor, the parent or legal guardian who accompanies the patient to his/her appointment is responsible for payment. We require that payment for services rendered be made at the time of each visit unless other arrangements have been made prior.

As a courtesy to our patients, we will file or assist you in filing a claim for services rendered in our office. Please remember that insurance is considered a method of reimbursing the patient for fees paid to our office and is not a substitute for payment. It is your responsibility to pay your account in full or for any balance that is not directly paid to our office by your insurance company. The actual amount your insurance company will pay is determined at the time your claim is processed. Your out-of-pocket costs may be affected by your insurance benefits such as individual deductibles, maximum amount in payable benefits, provider adjustments, and so forth.

To the extent necessary to determine liability for payment and to obtain reimbursement, you, the undersigned, authorize disclosure of portions of the patient's records and authorize payment of insurance benefits directly to Hoshino Endodontics LLC. You also understand that you are financially responsible for all charges incurred regardless of insurance coverage. You agree to pay any balance not paid by your insurance company.

Signature of Patient (Parent/Guardian if Minor)_____ Date_____

NOTICE OF PRIVACY PRACTICES

Please take the time to review our Notice of Privacy Practices. It explains how we may use and disclose your protected health information for treatment, payment, or health care operations. It also contains a Patient Rights section describing your rights under the law.

By signing below, you acknowledge that a copy of our Notice has been made available for your review, and you consent to the terms set forth in our Notice and any subsequent changes.

Signature of Patient (Parent/Guardian if Minor)_____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2023, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a written copy of our Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, 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 on our website. 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.

Contact Officer: Hsiao-Ling Hoshino, DMD, MS, MPH
Address: 1150 South King Street, Suite 607, Honolulu, HI 96814
Phone: (808) 202-2066
Fax: (808) 213-3088
Email: office@hoshinoendo.com