Island Ohana Dental
519 E. Lanikaula Street
Hilo, Hawaii 96720
Phone: (808) 935-4800 Fax: (808) 935-4870

TO OUR VALUED PATIENT: PLEASE DO NOT LIST ANY PHONE NUMBERS ON THIS FORM THAT YOU DO NOT WANT USED WHEN CONFIRMING APPOINTMENTS OR LEAVING MESSAGES

<**PATIENT INFORMATION**>

Name_____Date of Birth _____ _____/_____ _____/_____ ___
Last First MI

Social Security # _____ _____ _____ - _____ _____ - _____ _____ _____ _____ Patient is: Male ☐ Female ☐ Married ☐ Single ☐ Child ☐

Mailing Address_____

Street Address_____

_____ _____ _____
Home Telephone Cellular / Pager/ Voicemail E-Mail Address

_____ _____
Employer Work Telephone

If patient is a child, child resides with BOTH PARENTS ☐ FATHER ☐ MOTHER ☐ LEGAL GUARDIAN ☐ FOSTER FAMILY ☐

Is patient a full-time student? YES ☐ NO ☐ Student of _____ Grade _____

<**SPOUSE INFORMATION**>

Name of Spouse _____

Spouse's Date of Birth ____ ____ / ____ ____ / ____ ____

#____ ____ ____ - ____ ____ - ____ ____ ____ ____
Spouse's Social Security

Spouse's Employer _____

Telephone_____

<**PARENT/GUARDIAN INFORMATION**>

Father's Last Name _____

First Name _____ MI _____

Father's Date of Birth ____ ____ / ____ ____ / ____ ____

#____ ____ ____ - ____ ____ - ____ ____ ____ ____
Father's Social Security

_____
Father's Employer

_____
Work Telephone

<**FAMILY PHYSICIAN INFORMATION**>

Name of Family Physician _____

_____
Telephone

Name of Pediatrician _____

_____
Telephone

Mother's Last Name _____

First Name _____ MI _____

Mother's Date of Birth ____ ____ / ____ ____ / ____ ____

#____ ____ ____ - ____ ____ - ____ ____ ____ ____
Mother's Social Security

_____
Mother's Employer

_____
Work Telephone

<**INSURANCE INFORMATION**>

Primary Insurance Co _____ Secondary Insurance Co _____

Primary Insurance Plan/Group _____ Secondary Insurance Plan/Group _____

HMSA Medicaid# _____ Other Coverage_____

Whom may we thank for referring you to our office? _____ Yellow Pages _____ Other _____

I authorize GARRET K UEHARA DDS, Inc to administer such medications and perform such diagnostic and therapeutic procedures as prescribed in my treatment plan. I also authorize my group dental insurance benefits to be paid directly to GARRET K UEHARA DDS, Inc that are otherwise payable to me. I accept responsibility for all costs and fees incurred in my treatment that are otherwise not covered by my insurance company. All information provided is accurate to the best of my knowledge.

_____ _____
Patient Signature Date Parent/Legal Guardian Signature Date