MALAMA
DENTAL 4 KIDS

Dear Parent(s) or Legal Guardian(s):

We are honored to have the upcoming opportunity to treat your child. New patient appointments help determine future dental needs for your child. Depending on their age and dental need, the appointment will include an **exam, teeth cleaning, topical fluoride treatment, and dental x-rays.** Patients will be referred to a general dentist between the ages of 11 and 13, depending on each child's dental health needs.

Every effort is made to stay on schedule. We respectfully ask patients to be prompt and keep their scheduled appointments. Our standard office policies regarding patient appointments are as follows:

- **Appointment Confirmations** – You will receive confirmation phone calls, emails and/or text messages. (*standard text messaging rates may apply*)

- **Co-Payments** – Co-payments are due at the end of each appointment.

- **Late Appointments -** It is important for our patients to arrive promptly for their scheduled appointments. If you are more than **10 minutes late,** the appointment will be rescheduled.

- **Cancellations and Changes -** A **24 hour notice** is required if you are unable to keep the scheduled appointment. You may contact us by phone, email or text (located on the bottom of this notice.)

- **Missed Appointments** - After your **3rd missed appointment**, we will no longer be able to accommodate your family's dental health needs. **If a new patient appointment is missed, we will not reschedule the missed appointment.**

- **One (1)** person may accompany your child into the exam area for the initial visit.

If you have any questions or concerns regarding your child's appointment, please contact us.

Sincerely,

Malama Dental 4 Kids, LLC
Ammon Kau, D.D.S.

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Child's Name_____Preferred Name_____Birth Date_____

Mailing Address_____ Zip Code _____Phone Number_____

Age_____Sex_____School_____Grade_____

Child resides with: _____ Language Spoken at Home: _____

Explain briefly why you brought your child in for dental care_____

Whom may we thank for this referral? _____

CHILD'S HISTORY - IN ORDER TO RENDER THE BEST POSSIBLE CARE AND TREATMENT FOR YOUR CHILD, YOUR ASSISTANCE IS NEEDED IN ANSWERING ALL OF THE FOLLOWING QUESTIONS.

1. Who is your child's physician? _____Reason for last visit? _____

2. Are your child's immunizations current? ***Yes or No***

3. Has your child ever been hospitalized? _____When and why? _____

4. Does your child have or has your child ever had any of the following?
   ___mouth habits - thumb sucking, nail biting, pacifier, nursing bottle
   ___clenching teeth ___asthma ___heart condition ___Down's Syndrome
   ___grinding teeth ___tuberculosis ___epilepsy ___ADD ___AD/HD
   ___unusual speech habits ___diabetes ___Autism ___other_____

5. Does your child have any allergies? ***Yes or No*** List: _____

6. Is your child sensitive or allergic to latex? (ie. Experienced itching, rash or wheezing after latex gloves or handling a balloon) ***Yes or No*** If Yes, explain reaction:_____

7. Is your child taking any medication(s) now? ***Yes or No*** Purpose: _____

   Medication List: _____

8. Child's last visit to the dentist_____ Name of dentist? _____Were x-rays taken? ***Yes or No***

9. Is your child currently receiving daily fluoride? _____ In what form? _____

10. Does your child have a toothache now? _____ Has your child ever had one? _____

11. Are there any questions you have regarding your child's dental development or care? _____

_____

12. Name(s) and age(s) of sibling(s)_____

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Father/Legal Guardian's Name: _____Birth Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

S.S. No. _____ Home Phone _____
(*Social Security number must be given in order to submit a dental claim.)

Employer _____ Work Phone _____

Email _____ Cell Phone _____

Mother/Legal Guardian's Name: _____ Birth Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

S.S. No. _____ Home Phone _____
(*Social Security number must be given in order to submit a dental claim.)

Employer _____ Work Phone _____

Email _____ Cell Phone _____

Preferred Contact: Father Mother Legal Guardian By: phone / text / email

_____ Initial *I consent the dental practice of Malama Dental 4 Kids, L.L.C. to use my email address and/or cellphone number to text to discuss my child(ren)'s dental treatment, insurance, and my account. I understand I can withdrawal my consent at any time.

Primary Dental Insurance
Subscriber's Name_____ ___ no insurance

Subscriber/Member ID: _____ HMSA PPO Dental Code: _____

___HDS ___HMSA ___HMAA ___Quest ___Other _____

Secondary Dental Insurance
Subscriber's Name_____ ___ no insurance

Subscriber/Member ID: _____ HMSA PPO Dental Code: _____

___HDS ___HMSA ___HMAA ___Quest ___Other _____

AUTHORIZATION FOR ADDITIONAL DISCLOSURE OF A MINOR

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DENTAL 4 KIDS

I, the undersigned parent or legal guardian of _____ _____,
Patient(s) Name Date(s) of Birth
minor, do hereby authorize the below named caregiver(s), an adult into whose care my minor has been entrusted, to consent to a dental exam, teeth cleaning, fluoride treatment, and dental x-rays rendered to the minor by Ammon Kau, D.D.S. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority and power to render care which the aforementioned dentist in the exercise or her/his best judgment may deem advisable. ***I understand that any irreversible treatment such as fillings, crowns, or extractions must be reviewed with the parent or legal guardian as part of Informed Consent before any additional treatment can be rendered.***

Please initial in front of each item for which the above caregiver can be authorize.

_____ Consent for examination, dental x-rays, prophy (dental cleaning), and fluoride treatment

_____ Disclosure of pertinent medical or dental information

_____ Scheduling of appointments

List any restrictions_____

_____

Authorized Caregiver(s)

Name _____ DOB: _____ Relationship to Minor Child: _____

Driver's License State & #: _____ Best Contact Number _____

Name _____ DOB: _____ Relationship to Minor Child: _____

Driver's License State & #: _____ Best Contact Number _____

Parent or Legal Guardian Contact Where May be Reached during appointment

Father/Legal Guardian Home _____ Work _____ Cell _____

Mother/Legal Guardian Home _____ Work _____ Cell _____

This consent shall remain effective until the undersigned provides a written cancellation request.

Signature of Father, Mother or Legal Guardian _____ Date _____

275 Ponahawai Street, Ste 204 808-961-6704 call/text littlesmiles808@gmail.com

NOTICE OF PRIVACY PRACTICES

MALAMA DENTAL 4 KIDS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN 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 (4/14/2003) 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this 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 or 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 at any time in writing. Your revocation will not affect any use of 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, 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, or 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 official's 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 voice mail 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, for the last 6 years, but not before April 14, 2003. 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 location, and provide satisfactory explanation of 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 Web site or by electronic mail (e-mail), 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.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to 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 at the end of this Notice. 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: Sasha