Broken Appointment Policy: We respect your time

Your time is important, and we will be ready to serve you. Unlike many medical and dental offices, we do not double book our schedule. This allows you to receive focused & attentive care, but requires everyone be respectful & on-time.

When unexpected events interfere with scheduled appointments:

- For appointments that are suddenly cancelled or rescheduled by our office with less than 24 hours notice to you, we offer you a **$60 office credit** to be used toward future charges. Similarly, we offer this credit if we have made you wait in our waiting room for more than 40 minutes past your scheduled appointment time, if you were properly on time.
- For appointments that are broken by patients with **less than 24 hours notice**, for any reason, there will be a **$60 fee per scheduled patient**. This pays a portion of the staff & office time we have reserved for your family. Similarly, arriving late for an appointment may prevent our team from properly treating your child, and the appointment may be considered broken.
- A parent that casually breaks an initial office appointment with us is strongly invited to pursue a relationship with another dental office. Flaky is not welcomed.
- Exceptions to these rules will be made for large scale natural disasters, such as hurricanes or tsunamis.

Our goal is for all of us to maintain basic courtesy and respect for each other.
Thank you -- Blue Whale Children's Dentistry of Hawaii

BLUE WHALE
Children's Dentistry of Hawai'i

Patient Information

Child's Legal Name _____ Nickname _____

Gender M / F School _____

Birthday _____ Phone at Child's Main Residence _____

Legal Guardian Information

Legal Name _____ Preferred Name _____

Birthday _____ Gender M / F Marital Status _____

Home Address _____ City, State, Zip_____

Cell Phone_____ Other Phone (if preferred) _____ Occupation_____

Additional Legal Guardian Information

Legal Name _____ Preferred Name _____

Birthday _____ Gender M / F Marital Status _____

Cell Phone_____ Other Phone (if preferred) _____ Occupation_____

Patient's Primary Dental Insurance Information

Subscriber's Name _____ Subscriber's Birthday _____

Insurance Company _____

ID#_____ Group # _____

Patient's Secondary Dental Insurance

Subscriber's Name _____ Subscriber's Birthday _____

Insurance Company _____

ID#_____ Group # _____

Names of other adults that may be involved with care or transportation of the child (grandparents, nanny, etc).

_____

How did you learn of our office? / Whom may we thank for referring you to Blue Whale?

_____

This information is correct, and I have also reviewed the Blue Whale HIPAA Policy and ***$60 Broken Appointment Policy,*** which are available at the office front desk, and online. I understand that ***I am fully financially responsible*** for any service that I have approved or requested for my child. As a courtesy to me, the Blue Whale staff may attempt to estimate my insurance coverage, and may submit insurance claims on my behalf, but ultimately I am responsible for any copayments or services not paid by the insurance plan I have independently selected for my family.

Name _____

Signature _____ Date _____

BLUE WHALE
Children's Dentistry of Hawai'i

About your child:

Child's name: _____ Date of birth: _____/_____/_____ Gender: M F

Name of Legal Guardian/Parent: _____ phone: _____

Additional Legal Guardian/Parent: _____ phone: _____

Name of Pediatrician: _____ phone: _____

Name of other medical specialists: _____ phone: _____

Medical History:

- Is this child current with immunizations against childhood diseases? ❑ No ❑ Yes
- Currently undergoing any medical or psychological treatment? ❑ No ❑ Yes _____
- Currently taking any prescription medications? ❑ No ❑ Yes _____
- Ever had surgery, or been hospitalized for any reason? ❑ No ❑ Yes _____
- Ever had an adverse or allergic reaction to any drug or anesthetic? ❑ No ❑ Yes _____
- Have any heart, liver, kidney, bleeding, or breathing problems? ❑ No ❑ Yes _____
- Have any learning delays or disabilities, communication impairments, ADHD, or been suspected of being on the autism spectrum? ❑ No ❑ Yes _____
- Have cerebral palsy, brain injury, epilepsy, or convulsions/seizures? ❑ No ❑ Yes _____
- Is there any other significant medical history not mentioned above? ❑ No ❑ Yes _____

Oral Health Questions:

- When and where was this child's last dental visit? _____
- Does this child complain of oral discomfort? ❑ No ❑ Yes _____
- Does this child currently receive fluoride supplements? ❑ No ❑ Yes _____
- Has this child exhibited challenging behavior at any prior medical or dental offices? ❑ No ❑ Yes _____
- Do you have specific topics you'd like to discuss with the dentist? ❑ No ❑ Yes _____

_____

Other Questions:

- What are some of this child's interests and hobbies? _____
- Does the household maintain any religious, cultural, or lifestyle choices that we should consider when making recommendations for dental treatment? ❑ No ❑ Yes _____

_____

Name of Parent/Legal Guardian: _____

Signature: _____ Date: _____