HAWAII HOLISTIC DENTISTRY

David T. Doi, DDS
Trevor Hartwell, DDS

Patient Registration

Date: / /

Answers to the following questions are for our records only. They will be considered confidential and will become part of your permanent dental record.

Patient's Name: _____ ___Male ___ Female

Social Security Number: / / Date of Birth: / /

How would you like to be addressed (Dr./Mr./Ms., Nickname, etc.)? _____

Mailing Address
Street or PO Box _____ Unit # _____

City _____ State _____ Zip Code _____

Physical Address
Street _____ Unit # _____

City _____ State _____ Zip Code _____

Telephone Home _____ Cell _____

Employer	Present Position
Work Address	Work Phone#
Spouse's Name	Date of Birth: / /
Spouse's Employer	Present Position
Who will pay this account	Relationship

Whom may we thank for the referral? _____

NOTE: As a courtesy to our patients, an attempt will be made to confirm your appointment. A FEE of $60 per hour of the estimated duration of your appointment will be charged for each failed appointment (whether confirmed or not) without 24 hours notice.

PLEASE INTIAL Acknowledgement _____

Primary Dental Insurance Coverage	Secondary Dental Insurance Coverage
Name of Insurance Company	Name of Insurance Company
Subscriber	Subscriber
Subscriber Policy #	Subscriber Policy #
Group #	Group #
Subscriber Date of Birth / /	Subscriber Date of Birth / /