Patient Information Form

In order to serve you properly, we need the following information. All information is strictly confidential. Please Print clearly.

Referred By _____ Preferred appt. time & day _____ Preferred Dentist_____

Patient Name _____ Birthdate _____ Gender Male__ Female__0ther_____
(Last) (First) (Middle)

GENERAL

Social Security # _____-_____-_____ Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Widow☐

Address _____ City _____State_____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Occupation_____ If student, name of school _____

Employer _____ Work Phone ( ) _____ Ext. _____

Address _____ City _____ Zip Code _____

Name of Spouse (or parent/legal guardian if under 18) _____ Phone ( ) _____

Address_____ SSN of spouse (or guardian if under 18) ____-____-____

In case of emergency- Name of nearest relative or friend _____

Address _____City_____ Zip Code _____ Phone ( ) _____

Do we have your permission to discuss financial, medical, and personal information on your cellular phone? YES / NO

If not, please provide other phone #_____

MEDICAL

Chief complaint/ Reason for visit _____

List any allergies you have (latex, drugs, food, pollen, animals, etc.) _____

List any medications, vitamins, herbs you are taking _____

( ) See attached list (ask receptionist for a separate medication list if more space is needed)

Have you taken diet pills containing "fen-phen", fenfluramine (Pondimin), dexfenfluramine (Redux) YES / NO?

Are you taking medicine for Osteoporosis? YES / NO For How Long? _____

Circle name: Bisphosphonates Fosamax Actonel Boniva Areda I.V. Reclast I.V. Zometa I.V.

Other medications_____

Describe any condition we should know about _____

Do you wish to talk to the dentist privately about any problem? YES NO

Do you have: Dry Mouth (Xerostomia)? YES / NO Snoring? YES / NO Obstructive sleep apnea? (OSA) YES / NO CPAP? YES / NO
TMJ/TMD pain? YES / NO High cholesterol? YES / NO High Blood Pressure? YES / NO Diabetes? YES / NO Asthma? YES / NO

By signing below, I have reviewed and answered every question completely and accurately; if anything changes, I will inform my dental care provider as soon as possible.* A medical consultation may be necessary before providing dental treatment for your health and safety. MD name and phone number _____

X_____ _____ _____ _____ _____

Patient signature or Parent/legal guardian if minor Date Staff Initial Dentist Signature Date Reviewed

Revised 4/2/2021

Health History

Patient Name _____ Birthdate _____ Social Security # ___-___-____

CIRCLE APPROPRIATE ANSWER (ask for help if you do not understand any questions)

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year? Explain _____
3. YES NO Have you been hospitalized or had a serious illness in the last three years? Why? _____
4. YES NO Are you being treated by a physician now? For what? _____
5. YES NO Have you had problems with prior dental treatment? Date of last Medical Exam _____ Date of last dental appt. _____
6. YES NO Are you in pain now?

HAVE YOU EXPERIENCED:

7. YES NO Chest pain (angina)?
8. YES NO Swollen ankles
9. YES NO Shortness of breath
10. YES NO Recent weight loss, fever, night sweats?
11. YES NO Persistent cough, coughing up blood?
12. YES NO Bleeding problems, bruising easily?
13. YES NO Sinus problems?
14. YES NO Difficulty swallowing?
15. YES NO Diarrhea, constipation, blood in stools?
16. YES NO Frequent vomiting, nausea?
17. YES NO Difficulty urinating, blood in urine?
18. YES NO Dizziness, vertigo?
19. YES NO Ringing in the ears?
20. YES NO Headaches or migraines?
21. YES NO Fainting spells?
22. YES NO Blurred vision?
23. YES NO Seizures
24. YES NO Excessive thirst? Dehydration?
25. YES NO Frequent urination?
26. YES NO Dry Mouth?
27. YES NO Jaundice?
28. YES NO Joint pain, stiffness?

DO YOU HAVE OR HAVE HAD:

29. YES NO Heart disease?
30. YES NO Heart Attack, heart defects?
31. YES NO Heart murmurs?
32. YES NO Rheumatic fever?
33. YES NO Stroke, hardening of arteries?
34. YES NO High blood pressure?
35. YES NO TB, emphysema, other lung disease?
36. YES NO Hepatitis, other liver disease?
37. YES NO Stomach problems, ulcers, gastric reflux?
38. YES NO Allergies to drugs, foods, medication?
39. YES NO Family history: diabetes/heart problems/tumors?
40. YES NO HIV, AIDS or ARC?
41. YES NO Tumors or cancers?
42. YES NO Arthritis, rheumatism?
43. YES NO Eye disease, cataracts, glaucoma?
44. YES NO Anemia?
45. YES NO Sexually Transmitted Diseases?
46. YES NO Herpes?
47. YES NO Kidney/bladder disease?
48. YES NO Thyroid or adrenal disease?
49. YES NO Diabetes?
50. YES NO Skin disease, eczema, acne, rosacea?

DO YOU HAVE OR HAVE YOU HAD:

51. YES NO Psychiatric care?
52. YES NO Radiation Treatments?
53. YES NO Chemotherapy?
54. YES NO Prosthetic heart valve?
55. YES NO Artificial joint?
56. YES NO Hospitalization?
57. YES NO Blood transfusion?
58. YES NO Surgeries?
59. YES NO Pacemaker?
60. YES NO Contact lenses?

ARE YOU TAKING:

61. YES NO Recreational drugs?
62. YES NO Drugs, medicines, (incl. Aspirin, cannibis)? Please list: _____
63. YES NO Tobacco in any form?
64. YES NO Alcohol?

WOMEN ONLY:

65. YES NO Are you or could you be pregnant or nursing?
66. YES NO Taking birth control pills?

ALL PATIENTS:

67. YES NO Do you or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature _____ Date _____

RECALL REVIEW:

1. Patient Signature _____ Any changes? ☐YES ☐ NO _____ Staff initial Date _____
2. Patient Signature _____ Any changes? ☐YES ☐ NO _____ Staff initial Date _____
3. Patient Signature _____ Any changes? ☐YES ☐ NO _____ Staff initial Date _____
4. Patient Signature _____ Any changes? ☐YES ☐ NO _____ Staff initial Date _____

Rev 4/2/2021

Stephen M. Lee, DDS & Diana C. Fong, DDS Office Financial Policy

ALL OF THE INFORMATION BELOW MUST BE READ, COMPLETED AND SIGNED IN ORDER FOR THE DOCTOR TO SEE YOU

PAYMENT POLICY:
I hereby agree to pay my account as services are provided unless other financial arrangements have been made. We accept cash, Visa, MasterCard, Discover, American Express, and personal checks. Payment by phone is acceptable during regular business hours. Copayments and any deductible are due at the same time of service.

If for any reason any portion of my bill is not paid by my insurance, I will make arrangements for prompt payment of the balance or I will call my insurance company. Please call our office (510)272-0967 or (510)272-0929 if there are any questions regarding your bill during regular business hours. Our FAX is (510)272-0969.

OTHER IMPORTANT FINANCIAL INFORMATION:

1) There is a $35 charge for all returned checks _____ INITIALS

2) A $50 fee will be charged for missed appointments not cancelled (24) twenty-four hours prior to the scheduled appointment on weekdays and 48 hours advance notice is requested on Saturdays. PLEASE NOTE: WE DO CONDUCT COURTESY CALLS PRIOR TO YOUR APPPOINTMENT: HOWEVER IT IS NOT OUR RESPONSIBILITY TO REMIND YOU. We will call phone number ( )_____to leave a message if possible _____ INITIALS

3) In the event that your account must be turned over to collections, a collection fee equal to 50% of the balance will be added to your account. Balances overdue past 90 days may be turned over to collections. _____INITIALS

I HAVE READ, UNDERSTOOD, AND AGREE TO THE OFFICE AND FINANCIAL POLICY

Signature: _____ Date: _____ Staff Signature_____
(Patient or parent/legal guardian if under 18)

******** INSURANCE POLICY, INSURANCE ASSIGNMENT AND RELEASE OF PROTECTED HEALTH INFORMATION**********

1) Patients with PPO insurance with which we contract should only be ultimately responsible for co-payments, deductibles & upgrade fees provided all information by the responsible party is accurate and any required pre-authorizations have been obtained prior to treatment. The patient will be responsible for paying the bill when the insurance maximum has been reached, for non-covered medically necessary services and for most cosmetic dental treatment. Patients with discounted insurance plans will be financially responsible for all charges at the time of service. _____INITIALS

2) Even though this dental office will do its best to pre-verify eligibility, it is still the responsibility of the responsible party to maintain and verify eligibility with insurance companies, regardless of whether one has public (Denti-Cal) or private insurances.
_____INITIALS

3) I authorize direct payment of dental benefits to Dr.Stephen M. Lee, DDS & Dr. Diana C. Fong, DDS through my insurance company and I will pay-in-full the estimated charges for each visit at the time of visit unless I have made prior financial arrangements with the office. I understand this assignment will stay in effect as long as the patient remains in this practice. I understand that I must submit a current and valid insurance card or information in order to have the insurance company billed directly. I understand that if I fail to submit valid and current insurance card or information or if I fail to provide a valid secondary insurance card or information, I will be billed at the non-contracted rate for services provided. I agree to pay within 15 days of my billing date. I understand that any insurance disputes will be settled between the insurance company and me and any unpaid balance will be due and payable within 15 days of the billing date. _____INITIALS

<u>Release of Information- INSURANCE ONLY</u>
I authorize the release of any medical information necessary (x-rays, photos, dental / medical history, etc.) to process claims.

Signature: _____ Date: _____
(Patient or parent/legal guardian if under 18)

<u>Assignment of benefits –INSURANCE ONLY</u>
I authorize payment of dental benefits to Stephen M. Lee, DDS & Diana C. Fong, DDS for professional services rendered.

Signature: _____ Date: _____ Revised 5/24/2014
(Patient or parent/legal guardian if under 18)

HIPPA Consent Form for Use or Disclosure of Patient Health Information (PHI) – Dr. Stephen M. Lee & Dr. Diana C. Fong

Instructions: *Please complete. You may request a copy of this completed form. For questions, ask to speak with the dental practice's privacy officer.*

I, [patient's name or representative]_____authorize use or disclosure of my protected health information to third party entities for the purpose of

1. For treatment
2. To obtain payment for treatment
3. For healthcare operations or as required by law enforcement

I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following:
[ ] X-rays, photographs, dental history, medical history for insurance claims and specialist referrals. *(you may note dates, procedures or use other description here)*

_____

_____

Signature: _____

Print name:_____

Date Signed: _____This authorization is valid until _____or 3yrs

Signed by: ☐ Patient ☐ Parent/legal guardian if under 18 years old

☐ Personal representative of the patient — *describe the legal authority that permits the representation:*_____

Covid-19 Patient Screening Form

Instructions for use: Use one form for each patient appointment. Ask the patient these questions at the time appointment is made or with appointment reminder, and again no more than two days before the appointment.

Patient/Parent/Guardian Names: _____

Screening questions	Date: / / Staff initial:___	Date: / / Staff initial:___	Notes
Are you fully vaccinated for COVID-19?	☐ No ☐ Yes	☐ No ☐ Yes	*An individual is considered fully vaccinated if it has been more than 2 weeks since they received the last shot of a 2-dose vaccine (for example, Moderna or Pfizer) or a single dose vaccine (J&J). If the answer is yes, screen for symptoms only and not for close contact, COVID-19 testing or travel. Observational screening, instead of questioning patient about symptoms or having patient complete a form, should be noted in the patient chart.*
Do you have a fever or above normal temperature (>100.0° F)? *Take temperature at appointment.*	☐ No ☐ Yes	☐ No ☐ Yes	*If patient answers "yes," note the symptoms reported and seek additional information from the patient about possible cause. If patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve.*
Are you experiencing more than one of the following symptoms: shortness of breath, dry cough, sore throat, unexplained muscle pain, headache or nausea, new loss or taste or smell?	☐ No ☐ Yes	☐ No ☐ Yes	*If patient answers "yes," note the symptoms reported and seek additional information from the patient about possible cause. If patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve.*

Screening questions	Date: / / Staff initial:___	Date: / / Staff initial:___	Notes
Even if you don't currently have any of the above symptoms, have you experienced more than one of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*If "yes" and patient does not need emergency care, do not see patient unless it has been more than 10 days since symptoms first appeared and 24 hours of no fever without use of fever-reducing medication.*
Have you been advised to quarantine due to close contact with someone diagnosed with COVID-19?	☐ No ☐ Yes	☐ No ☐ Yes	*If yes, ask when the quarantine period ends and set appointment time after that date.*
Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.* ***If yes**, what is the result of the testing?* ***If negative,** proceed to next question.* ***If still waiting on results,** schedule appointment after results are known.*	☐ No ☐ Yes ☐ No ☐ Unsure ☐ Positive	☐ No ☐ Yes ☐ No ☐ Unsure ☐ Positive	*If positive, determine if patient needs emergency care. If not an emergency, schedule patient to be seen when it has been more than 10 days (20 days if patient illness was severe) since symptoms first appeared and 24 hours of no fever without use of fever reducing medication.*
Have you traveled out of state or out of country in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*Fully vaccinated individuals need not quarantine, according to the CDC. Know your county's health officer orders with regard to non-essential travel by individuals not vaccinated for COVID-19. The county orders will have quarantine recommendations.*

Patient signature required at appointment:

I agree to notify the dental practice if within 2 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had close contact with tested positive for COVID-19 within 2 days.

Acepto dar aviso a la clínica dental si dentro de dos días presento síntomas de COVID-19 o tengo un resultado positivo de COVID-19. Entiendo que la clínica dental tiene la obligación legal y ética de informarme si un miembro del personal con el que tuve contacto ha tenido un resultado positivo de COVID-19 dentro de dos días.

Signature_____