BRIEN HSU DDS INC., PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**) Date_____

Patient's Name_____ Age____ Patient's Birthday_____ ☐Male ☐Female
LAST FIRST M INITIAL

If patient is a minor, give name of parent or legal guardian_____Relationship_____

Patient is ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Minor Driver's License No._____

Residence Address_____
STREET CITY ZIP

Social Security No._____ Residence Phone (_____)_____ Cell Phone (_____)_____

Employed by_____ Occupation_____

Business Address_____Business Phone (_____) _____
STREET CITY ZIP

Spouse Name_____ Driver's License No._____ Social Security No._____

Employed by_____ Occupation_____

Business Address_____ Business Phone (____)_____

Emergency Contact_____ Relationship_____

Complete Address_____ Residence Phone (____)_____
STREET CITY ZIP ☐I have no physician

Name of Physician_____ (____) _____
ADDRESS TELEPHONE

Former Dentist_____ (_____)_____
ADDRESS TELEPHONE

Why are you changing dentists?_____

FINANCIAL INFORMATION

Person responsible for this account_____ Relationship_____

Address_____ (_____) _____
STREET CITY ZIP TELEPHONE

Name of insurance company (primary insurance)_____

_____
INSURED PERSON'S NAME BIRTHDAY RELATIONSHIP SOC. SEC. NO.

_____
NAME OF GROUP DENTAL PLAN GROUP NO.

Name of insurance company (secondary insurance)_____

_____
INSURED PERSON'S NAME BIRTHDAY RELATIONSHIP SOC. SEC. NO.

_____
NAME OF GROUP DENTAL PLAN GROUP NO.

TERMS AND CONDITIONS

I hereby authorize Dr. Hsu and his staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis. I give permission for this office to give reminder calls to my home and/or office in regards to appointment times and dental procedures. I understand that I will be responsible for fee, if I do not notify the office a minimum of 24 hours before canceling my scheduled appointment.

I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to myself. I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed upon dates, I understand that a late charge may be added to my account not to exceed 1.5% (18% APR). I understand that the fee estimate for dental treatment can only be extended for a period of six months from the date of the patient's examination.

To the extent permitted under applicable law, I authorize release of any information, including diagnosis and the records of any treatment or examinations rendered to my child or myself during the period of such dental care to third party payers and other health practitioners. I understand that this office makes every effort to maintain patient privacy. The staff is trained using the HIPAA guidelines on the most effective way of maintaining the patient's most private and personal information. I acknowledge that I have read the Notice of Privacy Practices and have been offered a copy of the Notice. Should I wish to obtain another copy or have any questions, I will contact the Front Desk/Privacy Officers. I acknowledge that I have read and have access (from the front desk) to a copy of the Dental Materials Fact Sheet.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

BRIEN HSU DDS INC., HEALTH QUESTIONNAIRE

MEDICAL HISTORY

1. Date of your last physical examination?_____
2. Are you now under the care of a physician?…….. Yes No
   If so, what is the condition being treated?_____
3. Have you ever had any serious illness or operation?…….. Yes No
   If so, what illness or operation?_____
4. Have you ever been hospitalized?…….. Yes No
   If so, what was the problem?_____
5. Are you taking any medications, drugs or herbs?….……Yes No
   If so, what?_____
   What dosage?_____
6. Have you ever been premedicated with antibiotics for your dental treatment?……..Yes No
7. Are you sensitive or allergic to any drugs or materials?……Yes No
   If yes, what drugs?_____
8. Do you take or have you ever taken Bisphosphonates (Fosamax,Boniva,Actonel, Aredia, Zometa etc.) for Osteoporosis, Chemotherapy or any other condition? Yes No

9. Do you have or have you had any of the following: (Please mark '**Y**' for Yes or '**N**' for No - answer all conditions):

Y N	Allergies to Acrylics	**Y N**	Diabetes Type ____	**Y N**	High Blood Pressure	**Y N**	Psychiatric Treatment
Y N	Anemia	**Y N**	Emphysema	**Y N**	HIV Related Complex	**Y N**	Radiation Treatment
Y N	Angina Pectoris	**Y N**	Epilepsy or Seizures	**Y N**	AIDS	**Y N**	Respiratory Disease
Y N	Artificial Prosthesis	**Y N**	Excessive Bleeding	**Y N**	Immune System Disorder	**Y N**	Rheumatoid Arthritis
Y N	Asthma	**Y N**	Fainting Spells	**Y N**	Joint Replacement	**Y N**	Rheumatic Fever
Y N	Blood Disease	**Y N**	Glaucoma	**Y N**	Jaundice	**Y N**	Sinus Trouble
Y N	Bruise Easily	**Y N**	Hay Fever	**Y N**	Kidney Disease	**Y N**	Sleep APNEA
Y N	Cancer	**Y N**	Heart Attack/Stroke	**Y N**	Liver Disease	**Y N**	Stomach Ulcers
Y N	Cerebral Palsy	**Y N**	Heart Murmur	**Y N**	Mental Disorder	**Y N**	Thyroid Disease
Y N	Chemotherapy	**Y N**	Hemophilia	**Y N**	Mitral Valve Prolapse	**Y N**	Tuberculosis
Y N	Cold Sores	**Y N**	Hepatitis Type ____	**Y N**	Nervous Disorders	**Y N**	Tumors or Growths
Y N	Congenital Heart Defect	**Y N**	Herpes	**Y N**	Osteoporosis	**Y N**	Venereal Disease

10. Do you have any disease, condition or problem not listed that you think we should know about?…….……Yes No
    If so, what?_____
11. Do you smoke? If yes, how much_____ Cigarettes Cigars Packs per day…….……Yes No
12. Do you wear a cardiac pacemaker, or have you had heart surgery?……...……Yes No
13. (Women) Are you pregnant? If so, how many months?_____……Yes No
14. (Women) Do you take any birth control medication or hormones?…….…..…..Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Lidocaine, novocaine, etc. injection for "numbing")?…….……... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic?……...…… Yes No
3. Have you had any serious trouble associated with any previous dental treatment?…….…….. Yes No
   If so, explain?_____
4. Would you desire to be pre-sedated?…….… Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the Terms and Conditions printed on the Patient Information sheet:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

BRIEN HSU DDS INC., DENTAL INFORMATION

Patient Name:_____

What is the reason for your visit today?_____

_____

When was your last dental visit?_____

Do you like your smile? Yes No

Do you have any dental problems now? Yes No

If yes, please describe:_____

If you snore (or someone says you snore) would you like information on how to eliminate or reduce your snoring? Yes No

DENTAL HISTORY

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal Treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so describe, including cause_____

_____

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where?_____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Do you:

Clench or grind your teeth? Yes No

Bite your lips or cheeks regularly? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/Chew tobacco? Yes No

Are you satisfied with your teeth's appearance:

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe_____

_____

_____

HOW DID YOU HEAR ABOUT US?

- Website : _____
- Friends: _____
- Family: _____
- Magazine: _____
- Welcome Wagon
- Brochure/Letter
- Phone Book (Verizon, Yellow Book USA, Other _____)
- Passed (drove/walked) by Plaza
- Other:_____

Authorization for the Release of Dental Information

California

I hereby authorize Brien Hsu DDS and staff, to release the information in the dental record of

_____ (patient's name) to

☐ All immediate family members

☐ _____
(name of patient's representative and/or family members)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____

_____

This authorization is effective now and will remain in effect:

☐ for the duration of being a patient of Comfort Care Dental, Brien Hsu DDS INC.

☐ until _____ (date).

I understand that I may receive a copy of this authorization.

_____ _____
Signature Date

If not signed by the patient please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point **(this is 8 point)**.

Place a copy in the patient's chart.

- Brien Hsu DDS INC. -

Comfort Care Dental
11458 Kenyon Way, Suite 120
Rancho Cucamonga, Ca 91701
(909) 941-2811

Insurance and Cancellation Policy

Please be assured that our well-trained staff have calculated all insurance estimates based on information provided by an insurance representative over the phone. However this is not a guarantee of insurance payment. If an insurance pre-authorization is provided, this is still not a guarantee of insurance payment. Current available benefits, coverages, and patient eligibility, may not be accurate at the time of service. Although rare, insurance companies have been known to make errors. As a courtesy, claims are submitted to the insurance on behalf of our patients. All unpaid balances are the responsibility of the patient.

Our doctor's time, dental staff, dental operatory, and dental materials and medication have been specially reserved for your appointment. Many of the materials and medication cannot be re-used once they are set up for an appointment. We ask that you notify us a minimum of 24 hours in advance, if you're unable to make your appointment. Unfortunately, failure to notify us within 24 hrs will result in a $50.00 cancellation fee (please note that the fee will be waived if unable to notify us because of an emergency).

Thank you for your understanding.

I have read the above acknowledgment and agree to the terms and conditions.

_____
Printed Patient Name/Date

_____
Signature of Responsible Party/Date

_____
Signature of Dental Staff

- Brien Hsu DDS INC. -

Comfort Care Dental
11458 Kenyon Way, Suite 120
Rancho Cucamonga, Ca 91701
(909) 941-2811

INFORMED CONSENT FOR COMMUNICATION

Regarding Patient:_____ Date:_____

Our dental practice sends mail/email or calls for information about treatment, payment, appointment reminders, your account and insurance, and other communication. If a call is made and not answered, we will leave a voicemail message regarding the above information. Please tell us how and where you would like us to communicate with you.

Complete ALL that apply (please print clearly):

Contact me by U.S. Mail at the following address:

□ Same as residence address on Patient Information form from: _____
Date

□ Different address:_____

_____

_____

Call me at:_____ and/or Email me at:_____

_____ _____

_____ _____
Patient/Guardian Signature Date

Please contact our office immediately if you obtain a new telephone number and/or physical/email address.