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

Dentist Name _____ (____)_____
ADDRESS TELEPHONE

Preferred Pharmacy _____ (____)_____
ADDRESS TELEPHONE

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 MEDICAL PLAN GROUP NO.

Name of insurance company (secondary insurance)_____

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

NAME OF GROUP MEDICAL 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 medical 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 doctor, insurance benefits otherwise payable to myself. I understand that my medical insurance carrier may pay less than the actual fee for services. I agree to be responsible for all charges for medical services and materials not paid by my medical benefit plan, unless the treating doctor or medical 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 medical 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 the patient or myself during the period of such medical 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.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

Patient name: _____

Brien Hsu DDS INC.

Medical Questionnaire

CC: State your reason for visiting clinic today:

Please answer all questions **by checking a box under YES or NO.** (Please do not draw a line).
Your response will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
☐	☐	Hypertension or high blood pressure
☐	☐	Heart disease from childhood
☐	☐	Heart murmur
☐	☐	Rheumatic fever
☐	☐	Use of Fen-Phen
☐	☐	Pacemaker
☐	☐	Vascular graft
☐	☐	Heart valve replacement
☐	☐	Heart attack (myocardial infarction)
☐	☐	Heart surgery
☐	☐	Congestive heart failure
☐	☐	Angina
☐	☐	Irregular heart beat
☐	☐	Stroke
☐	☐	Increased cholesterol

Endocrine/Hematologic/Oncologic/Immune:

YES	NO	
☐	☐	Frequent hunger
☐	☐	Frequent thirst
☐	☐	Diabetes-Type I, II
☐	☐	Thyroid disease
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Bleeding tendency
☐	☐	Anemia
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	HIV infection/AIDS
☐	☐	Organ transplant
☐	☐	Blood transfusion

Do you have, or did you ever have, any of the following?

Musculo-Skeletal/CNS/Developmental:

YES	NO	
☐	☐	Chronic jaw and facial pain
☐	☐	Chronic headache pain
☐	☐	Chronic neck pain
☐	☐	Popping or clicking in your jaw
☐	☐	Joint replacement
☐	☐	Osteoarthritis *(hands and knees)*
☐	☐	Rheumatoid arthritis
☐	☐	Spinal cord injury
☐	☐	Seizures
☐	☐	Dizziness
☐	☐	Weakness
☐	☐	Multiple sclerosis
☐	☐	Cerebral palsy
☐	☐	Intellectual disability
☐	☐	Dementia / Alzheimer's
☐	☐	Fainting spells
☐	☐	Visual impairment
☐	☐	Glaucoma
☐	☐	Hearing impairment

Gastrointestinal/ Genito-Urinary:

YES	NO	
☐	☐	Hepatitis (A, B, C or other)
☐	☐	Kidney dialysis
☐	☐	Ulcer
☐	☐	Sexually transmitted disease
☐	☐	Denied permission to give blood
☐	☐	Acid Reflux

Respiratory:

YES NO

- ☐ ☐ Asthma
- ☐ ☐ Chronic sinus problems
- ☐ ☐ Night sweats
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis
- ☐ ☐ COPD

Social:

YES NO

- ☐ ☐ Do you use tobacco products?
  If so, how much? _____
- ☐ ☐ Do you drink alcohol?
- ☐ ☐ Every day?
  If so, how much? _____
- ☐ ☐ Do you use recreational drugs?

Medication Allergy or Intolerance:

YES NO

- ☐ ☐ Penicillin
- ☐ ☐ Dental anesthetic ("Novocain")
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Latex products
- ☐ ☐ Iodine
- ☐ ☐ Other:_____

Do you have any medical condition not already mentioned?

_____

_____

History of Hospitalizations/Surgical Procedures:

_____

_____

_____

_____

Family: Did a parent, sibling or child of yours have any of the following?

YES NO

- ☐ ☐ Diabetes
- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease
- ☐ ☐ Bleeding tendency
- ☐ ☐ Cancer
- ☐ ☐ Other: _____

Psychological:

YES NO

- ☐ ☐ Anxiety/Nervousness
- ☐ ☐ Depression
- ☐ ☐ Mental health treatment
- ☐ ☐ Insomnia

Medications:

YES NO

☐ ☐ Are you taking any prescriptions, over-the-counter or herbal medicines now? If so, please list them and the doses you use:

_____

_____

_____

_____

_____

_____

_____

Do you or have you used bisphosphonate medication (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa® and Bonefos®) to prevent or treat osteoporosis or as part of a cancer treatment?

YES NO

☐ ☐

If YES, what type of Bisphosphonate? _____

How long have you been or were you taking the bisphosphonate?_____

Other:

YES NO

- ☐ ☐ Does the amount of saliva in your mouth seem to be too little?
- ☐ ☐ Does your mouth feel dry when eating a meal?

FEMALES ONLY:

YES NO

- ☐ ☐ Are you pregnant? Months:___?
- ☐ ☐ Do you take birth control pills?
- ☐ ☐ Are you breast-feeding now?

Signature _____

Date _____

Authorization for the Release of Medical and Dental Information

California

I hereby authorize Dr. Brien Hsu and staff, to release the information in the medical and or 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. -

Brien Hsu DDS, MS
Orofacial Pain, Oral Medicine, and Sleep Disorders.
11458 Kenyon Way, Suite 120 Rancho Cucamonga, CA 91701
P: (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, medical/dental staff, medical/dental operatory, and medical/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 Medical/Dental Staff

- Brien Hsu DDS INC. -

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INFORMED CONSENT FOR COMMUNICATION

Regarding Patient:_____ Date:_____

Our medical/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.