



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

- |                          |                          |                                      |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension or high blood pressure  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease from childhood         |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of Fen-Phen                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular graft                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart valve replacement              |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack (myocardial infarction) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestive heart failure             |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased cholesterol                |

**Endocrine/Hematologic/Oncologic/Immune:**

YES NO

- |                          |                          |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent hunger     |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent thirst     |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes-Type I, II |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease     |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia          |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding tendency   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia              |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer              |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy        |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV infection/AIDS  |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant    |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion   |

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

**Musculo-Skeletal/CNS/Developmental:**

YES NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic jaw and facial pain               |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic headache pain                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic neck pain                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Popping or clicking in your jaw           |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis ( <i>hands and knees</i> ) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal cord injury                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple sclerosis                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral palsy                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Intellectual disability                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dementia / Alzheimer's                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual impairment                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing impairment                        |

**Gastrointestinal/ Genito-Urinary:**

YES NO

- |                          |                          |                                 |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (A, B, C or other)    |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney dialysis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease    |
| <input type="checkbox"/> | <input type="checkbox"/> | Denied permission to give blood |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

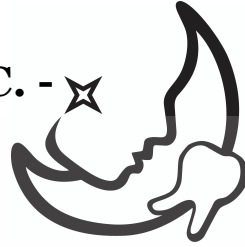
beneficiary or personal representative of deceased patient

**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

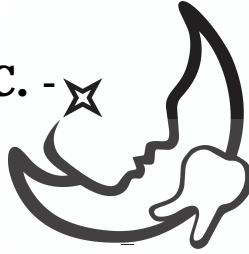
---

Signature of Responsible Party/Date

---

Signature of Medical/Dental Staff

**- Brien Hsu DDS INC. -**



**Brien Hsu DDS, MS**  
**Orofacial Pain, Oral Medicine, and**  
**Sleep Disorders.**  
11458 Kenyon Way, Suite 120  
Rancho Cucamonga, CA 91701  
P: (909) 941-2811

## 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.