FOSTER CITY
ORAL SURGERY SPECIALISTS
ORAL SURGERY | DENTAL IMPLANTS | WISDOM TEETH

1261 E Hillsdale Blvd, Suite 1
Foster City, CA 94404
Phone: (650) 525-1033
Fax: (650) 525-1833
WWW.FOSTERCITYOS.COM

PATIENT INFORMATION FORM

Please fill out the highlighted portion on both sides. If not applicable, please note N/A.
If you are under the age of 18, have a parent or guardian sign where indicated.

PATIENT INFORMATION

Patient's Full Name _____ Age _____ DOB _____

Gender at Birth ☐ Male ☐ Female Preferred Pronoun ☐ He ☐ She ☐ Other _____

Current Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Best Phone # _____ Email _____

Preferred Pharmacy _____

Referred By _____ Patient's Dentist _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Employer _____ Bus. Tel. _____

Emergency Contact Name _____

Relationship to Patient _____ **Phone #** _____

If you are here for a lesion/biopsy evaluation, please make sure to show your medical insurance to the front office.

INSURANCE INFORMATION

DENTAL PRIMARY INSURANCE	DENTAL SECONDARY INSURANCE
Insurance Company Name _____	Insurance Company Name _____
Insurance Phone # _____	Insurance Phone # _____
Insured's Name _____	Insured's Name _____
Relationship to You _____	Relationship to You _____
ID # _____ DOB _____	ID # _____ DOB _____
Group or Plan # _____	Group or Plan # _____
Insured Employer _____	Insured Employer _____

Please understand filing an insurance claim is an office courtesy; this does not relieve you of responsibility for your bill.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if under 18 years old)

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MEDICAL HISTORY FORM

Name _____ Date _____

Date of Birth _____ Sex ☐ M ☐ F Height _____ Weight _____

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

GENERAL INFORMATION

- Are you in good health? ☐ Yes ☐ No
- Has there been any change in your health in the past year? ☐ Yes ☐ No

  My last physical exam was on _____
- Are you now under the care of a physician? ☐ Yes ☐ No

  If so, for what condition? _____

  The name and address of my physician is _____
- Have you had any serious illness, operation, or hospitalization within the past 5 years? ☐ Yes ☐ No

  If so, what was the problem? _____

  _____

What is the purpose of your visit?

SPECIFIC INFORMATION

Cardiac (Heart)

Do you have or have you had any of the following?

a. High or low blood pressure ☐ Yes ☐ No
b. Heart trouble, heart attack, angina pectoris, or any other heart condition ☐ Yes ☐ No
c. Damaged heart valves, artificial valves, or heart murmur ☐ Yes ☐ No
d. Irregular heartbeat ☐ Yes ☐ No
e. Pacemaker placement ☐ Yes ☐ No

Respiratory (Lungs)

Do you have or have you had any of the following?

a. Persistent cough ☐ Yes ☐ No
b. Asthma ☐ Yes ☐ No
c. Respiratory problems, emphysema, bronchitis, etc. ☐ Yes ☐ No
d. Sleep apnea ☐ Yes ☐ No
e. Allergies ☐ Yes ☐ No
f. Sinus trouble ☐ Yes ☐ No

Endocrine Disorders

Do you have or have you had any of the following?

a. Diabetes ☐ Yes ☐ No
b. Thyroid disease ☐ Yes ☐ No

Bleeding and Blood Disorders

Do you have or have you had any of the following?

c. Abnormal bleeding from previous surgery or extractions ☐ Yes ☐ No
d. Required a blood transfusion ☐ Yes ☐ No
e. Any blood disorder (anemia, hemophilia, Von Willebrands, sickle cell anemia) ☐ Yes ☐ No
f. Do you bruise easily? ☐ Yes ☐ No

Infectious Diseases

Do you have or have you had any of the following?

a. Hepatitis (A, B, C, non-A, non-B) ☐ Yes ☐ No
b. Cold sores (oral herpes) ☐ Yes ☐ No
c. HIV/AIDS ☐ Yes ☐ No
d. Any disease, drug, or transplant operation that has suppressed your immune system ☐ Yes ☐ No

Joints

Do you have or have you had any of the following?

a. Artificial joint replacement (knee, hip, shoulder, etc.) ☐ Yes ☐ No
b. Arthritis or painful, swollen joints ☐ Yes ☐ No
c. TMJ problems (pain, popping, or clicking) ☐ Yes ☐ No

Neurologic & Muscle Problems

Do you have or have you had any of the following?

a. Fainting spells ☐ Yes ☐ No
b. Epilepsy or seizure disorder ☐ Yes ☐ No
c. Muscular dystrophy ☐ Yes ☐ No
d. Myasthenia gravis ☐ Yes ☐ No
e. Stroke ☐ Yes ☐ No

Other

Do you have or have you had any of the following?

a. Jaundice or liver disease ☐ Yes ☐ No
b. Stomach ulcer or reflux ☐ Yes ☐ No
c. Kidney trouble ☐ Yes ☐ No
d. Osteoporosis ☐ Yes ☐ No
e. Do you have or have you had cancer? ☐ Yes ☐ No
f. Have you ever had treatment for a tumor or growth? ☐ Yes ☐ No
g. Have you had radiation therapy to the head, neck, or jaws? ☐ Yes ☐ No

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MEDICAL HISTORY FORM (CONT.)

MEDICATIONS *Are you taking or have you ever taken any form of the following drugs?*

a. Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (bevacizumab, sunitinib, Fosamax®, Actonel®, Boniva®, Aredia®, or Zometa®)? ☐ Yes ☐ No
b. Antibiotics or sulfa drugs ☐ Yes ☐ No
c. Anticoagulants (blood thinners) ☐ Yes ☐ No
d. Medicine for high blood pressure ☐ Yes ☐ No
e. Cortisone (steroids) ☐ Yes ☐ No
f. Tranquilizers ☐ Yes ☐ No
g. Aspirin ☐ Yes ☐ No
h. Insulin ☐ Yes ☐ No
i. Digitalis or drugs for heart trouble ☐ Yes ☐ No
j. Nitroglycerin ☐ Yes ☐ No
k. Antihistamine ☐ Yes ☐ No
l. Oral contraceptive or other hormonal therapy ☐ Yes ☐ No
m. Chemotherapy drugs ☐ Yes ☐ No
n. Dilantin (anticonvulsants) ☐ Yes ☐ No
o. Fen-Phen ☐ Yes ☐ No
p. Are you taking any medicine(s), including diet pills, nonprescription, vitamins, or homeopathic or natural remedies? ☐ Yes ☐ No

List all medications you are now taking:

ALLERGIES *Are you allergic to or have you had a reaction to any of the following?*

a. Local anesthetics ☐ Yes ☐ No
b. Penicillin or antibiotics ☐ Yes ☐ No
c. Sulfa drugs ☐ Yes ☐ No
d. Codeine or other narcotics ☐ Yes ☐ No
f. Latex or rubber products ☐ Yes ☐ No
g. Other: _____

- Do you drink alcohol? ☐ Yes ☐ No
  How much? _____
- Do you smoke or chew tobacco? ☐ Yes ☐ No
  How much? _____
- Do you use recreational drugs? ☐ Yes ☐ No
- Is there any history of alcohol or chemical dependency? ☐ Yes ☐ No
- Do you have excessive nervousness or anxiety? ☐ Yes ☐ No
- Have you had psychiatric counseling? ☐ Yes ☐ No
- Have you had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No

  If so, explain:
- Have you or has anyone in your family ever been advised of any complications during any anesthetic (malignant hyperthermia)? ☐ Yes ☐ No
- Have you taken a general anesthetic or sedation in the past, either in the hospital or an office? ☐ Yes ☐ No
- Do you have any other condition or disease you think the doctor should know about? ☐ Yes ☐ No

  If so, explain:

WOMEN

- Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
- Do you have problems associated with your menstrual period? ☐ Yes ☐ No
- Are you nursing? ☐ Yes ☐ No
- Are you taking birth control pills? ☐ Yes ☐ No

I have read and I understand the above. Any questions I had about this form have been answered, and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if under 18 years old)

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MEDICAL HISTORY FORM (CONT.)

FOR COMPLETION BY THE DOCTOR

Significant findings from questionnaire or oral interview:

Doctor Signature: _____ **Date:** _____
(Parent or Guardian if under 18 years old)

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FINANCIAL AND OFFICE POLICIES

Welcome to our office! We have discovered that communication with our patients regarding our financial policies assists us in providing the best quality of services to you. We have therefore taken the time to answer some of the most commonly asked questions.

PAYMENT POLICY

We require that you pay any deductible, copayments, and fees at the time of your appointment. Our treatment coordinators will be happy to work with you to determine the extent of your insurance coverage and the amount needed on or before your surgical appointment. **We accept cash, personal checks, Visa®, Mastercard®, and Discover®.**

REGARDING INSURANCE

Our office participates with most dental insurance plans, and we will contact your dental insurance company to verify eligibility and benefits as accurately as possible. However, some services ***may not*** be covered by your plan, and information provided over the phone is not a guarantee of payment. We would advise you to contact your dental insurance company with any questions regarding your plan. Your dental insurance policy is a contract between you, your employer, and the insurance company. **We do not accept Denti-cal, Medi-cal, or Medicare.**

After your visit, we will file a claim as a courtesy to you. If accurate information is not provided to us, this can delay payment from your insurance. Most insurance companies will respond within 4–6 weeks. Please call our office if your statement does not reflect your insurance payment within that time frame. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated.

OUR TIME IS VALUABLE/YOUR TIME IS VALUABLE

If you are unable to keep your scheduled appointment, please contact us as soon as possible. As a courtesy to the doctor(s), staff, and other patients. **Cancellation of less than 72 hours in advance may result in a $100.00 cancellation fee for a consultation appointment and a $200.00 fee for surgery cancellations.** This applies to new patients as well as existing. We recognize how valuable your time is and will do our best to see you at your set appointment time.

INTEREST

Accounts with unpaid balances over 90 days will be charged the collection agency's recovery fee.

MINOR PATIENTS

Parents or guardians are responsible for all charges for minor children.

Thank you for taking the time to read our financial policy. We hope that it answers any questions you may have. If you have any concerns or other questions, please feel free to ask. We are here to help!

AUTHORIZATION

I authorize the oral surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of X-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if under 18 years old)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (11/01/07) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or another person to the extent necessary to help with your healthcare or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

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NOTICE OF PRIVACY PRACTICES (CONT.)

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $20 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

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NOTICE OF PRIVACY PRACTICES (CONT.)

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Linda H. Lee
Telephone: (650) 525-1033 Fax: (650) 525-1833
Email: info@fcoralsurgery.com
Address: 1261 E Hillsdale Blvd, Suite 1, Foster City, CA 94404

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if under 18 years old)