



Patient Information

Today's Date _____

First name _____ Last name _____ MI _____ Birth date _____
Social Security no. _____ Marital status: ☐ Single ☐ Domestic Partner ☐ Married ☐ Widowed ☐ Divorced
Residence address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____ Cell phone _____
If child, parent's name or guardian's name _____ Email _____
Guardian's Social Security no. _____ Guardian's Birth date _____
Employer _____ Address _____
Occupation _____ Driver's license _____

Insurance Information

Do you have insurance? ☐ Yes ☐ No If no, how do you intend to pay? ☐ Check ☐ Cash ☐ Credit Card
Name of subscriber _____ Subscriber's Social Security no. _____
Subscriber's Birth date _____
Ins. Co. name & address _____
Policy no. _____ Ins. Company phone no. _____
Is it through your employer? ☐ Yes ☐ No Name of employer _____
Name of spouse _____ Birth date _____
Spouse's Social Security no. _____ Is there secondary ins., Spouse 2nd carrier, etc? ☐ Yes ☐ No
Name & address of spouse employer _____ Business phone _____
Secondary Ins. name & address _____ Policy no. _____
Ins. telephone no. _____

Patient Responsibility

Person financially responsible for this account _____ Relationship to patient _____
Address _____
Nearest friend or relative not residing with you? _____ Relationship to patient _____
Phone _____ Who may we thank for referring you? _____
Their address _____
What is your chief complaint _____
I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.
Patient, Parent, or Guardian Signature _____ Date _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
			Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental Health Questionnaire



VALLEY FAMILY
DENTISTRY

Patient Name _____ Birthdate _____

Correct answers to the following will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Check yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

- Yes / No
1. What is the reason for your visit today? _____
 2. Are you having discomfort at this time? ☐ ☐
 3. Have you ever had any serious trouble associated with previous dental treatment? ☐ ☐
 - If so, please explain _____
 4. Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐
 5. Date of last dental visit? _____ What was done at that time? _____
 6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ ☐
 7. How often do you brush? _____
 8. Your toothbrush is: ☐ Soft ☐ Medium ☐ Hard

9. Do you have or have you ever had any of the following?

Yes / No

Yes / No

MOUTH

- | | | |
|--|--------------------------|--------------------------|
| Bleeding, sore gums..... | ☐ | ☐ |
| Unpleasant taste or bad breath..... | ☐ | ☐ |
| Burning tongue/lip..... | ☐ | ☐ |
| Frequent blisters, lips/mouth..... | ☐ | ☐ |
| Swelling/lumps in your mouth..... | ☐ | ☐ |
| Ortho treatment (braces)..... | ☐ | ☐ |
| Biting cheeks or lips..... | ☐ | ☐ |
| Clicking/ popping jaw..... | ☐ | ☐ |
| Difficulty opening or closing jaw..... | ☐ | ☐ |

TEETH

- | | | |
|--------------------------|--------------------------|--------------------------|
| Loose teeth..... | ☐ | ☐ |
| Sensitive to hot..... | ☐ | ☐ |
| Sensitive to cold..... | ☐ | ☐ |
| Sensitive to sweet..... | ☐ | ☐ |
| Sensitive to biting..... | ☐ | ☐ |
| Food impaction..... | ☐ | ☐ |
| Clenching/grinding..... | ☐ | ☐ |
| If so, when _____ | | |
| Shifting in bite..... | ☐ | ☐ |
| Change in bite..... | ☐ | ☐ |

10. Do you use the following?

Yes / No

- | | | |
|--|--------------------------|--------------------------|
| Toothbrush..... | ☐ | ☐ |
| Dental Floss..... | ☐ | ☐ |
| Flouride rinse..... | ☐ | ☐ |
| Other _____ | | |
| 10. Are you happy with your smile?..... | ☐ | ☐ |
| 11. Would you like the doctor to discuss about cosmetic treatments available to improve your smile?..... | ☐ | ☐ |

Additional Comments:

Patient Signature: _____ Date: _____ Doctor Signature: _____



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 **04/14/03**; 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 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 other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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, or 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.

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 authorize 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 **\$0.20** for each page, **\$20.00** per hour for staff time to locate and 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, 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: **Jason Hsiao D.D.S.**

Telephone: **(925) 449-1141** Fax: **(925) 449-7902**

Address: **60 Fenton Street, Suite #9 Livermore, CA 94550**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ Email: _____
Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting:

Contact Person: Jason Hsiao D.D.S.
Telephone: 925.449.1141 Fax: 925.449.7902
Email: info@valleyfamilydentistry.net
Address: 60 Fenton Street #9 Livermore, California 94550

Right to Revoke: You will have the right to revoke this Consent at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart



OFFICE POLICY REGARDING FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

Jason Hsiao D.D.S.
Valley Family Dentistry/Jason Hsiao Dental Corp.

Dr. Jason Hsiao

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance, and your understanding of our payment and insurance reimbursement policy.

As a service and convenience to you, we will file insurance claims for you. Your insurance coverage is a contract between you, your employer and the insurance company. We are not party in this contract. Our relationship is with you and not your insurance company. All charges are your responsibility.

It is your responsibility to confirm the doctor you are seeing is on your insurance provider list, and what charges will not be covered.

For those patients who are covered by insurance, we will accept assignment of benefits. This means that you must sign the portion of your insurance form that "assigns" payment to our office. Most dental insurance plans do not cover 100% of the cost of your treatment and set their own fee schedule. We will estimate as closely as possible your coverage, however, any amount not paid by your insurance company is payable by you. We will happily assist you in dealing with your insurance company, but the ultimate financial responsibility begins and ends with you.

IF YOU DO NOT HAVE INSURANCE:

We require you to sign a financial agreement for the total amount of your billing. Payment is due at each visit, as services are rendered, unless prior arrangements have been made.

If you have any questions about our financial policy, please do not hesitate to ask. We are here to help.

Signature _____ Date _____

Financial Policy

Dear Patient

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy.

Our primary goal is to provide you with the highest quality oral health care in the most gentle and efficient manner. Since our practice is also a business that with obligation must be met, payment for services is due at the time services are rendered. We ask that all of patient pay for their treatment in full on the day of each visit unless prior arrangement has been made.

We accept cash, personal checks, and for your convenience Bank Debt card, MasterCard, Discover, American Express, Visa, and Citi Health Card Financing. We will help you process your insurance claim for your reimbursement as long as you provide us with the accurate and complete insurance information before or at your visit.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company. Your treatment plan is individual planned for you, and is not based on the insurance benefits or lack of benefits. It is your responsibility to thoroughly understand the coverage and exception of your particular policy. Our front desk staff is trained to help you with questions you may have relating to how your claim is filed or regarding any additional information your insurance carrier may need to process your claim, please ask if you have any questions.

2. We will always do our best to maximize your benefit and provide you with rough estimates. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

3. If the insurance company does not pay in full within 45 days, we will require you to pay the balance due. Amount due and not paid in full within 30 days will be charged interest at rate of 1.5% per month in addition to a \$1 monthly billing statement processing fee. Balances older than 90 days will become a delinquent account and will be referred to Collection agency which may be subject to additional collection fees. Balance must be paid in full before any non emergency appointment can be scheduled.

4. Returned checks will have an additional fee of \$25.00 added to the amount of the total balance.

5. Please call our practice as soon as possible if you have to reschedule. Broken appointments add to the cost of dental care when trained personnel and facility are left waiting empty. Unless cancelled at least 48 hours in advance, you may be charged \$35 for repeated broken appointments.

We understand that temporary financial problems may affect timely payment of your account. We encourage you to communicate any such problems to us so that we can assist you in the management of your account. Again, thank you for choosing Valley Family Dentistry as your Dental health care provider. We appreciate your confidence in us, and the opportunity to serve you.

I understand and accept the financial policy listed above, and have had any questions answered to my satisfaction.

Patient's Signature: _____ Date: _____

Valley Family Dentistry