East Bay Dental 5157 Lone Tree Way, Antioch, CA, 94531

CONFIDENTIAL PATIENT INFORMATION v.071117

We may use your cell phone information and email to send you reminders and confirm your appointment, or send you patient satisfaction surveys.

Patient Information

Name: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

( ) Male ( ) Female ( ) Minor ( ) Single ( ) Married Social Security #: _____

Employed By: _____ Occupation: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

If the same as the patient, write "**SELF**"

Responsible Party Information

Name: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Employed By: _____ Occupation: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Insurance Information

Do you have dental insurance? ( ) No ( ) Yes (If YES, please complete the following information.)

	Primary Insurance	***Secondary Insurance***
Employed By:		
Person policy issued to:		
Member ID #:		
Name of Insurance Company:		
Group #:		
Date of Birth:		

We need the above information so that we can help you obtain the dental insurance benefits you are eligible for.This may require submitting the Doctor's treatment plan to the insurance company(s) for a pre-determination of benefits, or in some cases obtaining the information by phone. We can NEVER guarantee payment by your insurance company. The insurance company's contract is between you and your employer.

Emergency Information

Name: _____ Phone: _____ Relation: _____

Whom may we thank for referring you to our office? _____ Do you use Yelp regularly? ( ) Yes ( ) No

To help the doctor know you a little better, please provide the following optional information:

Do you have a nickname? _____

Name of your physician: _____ Phone: _____

Name of your former dentist: _____ Phone: _____

What is the purpose for today's visit? _____

EAST BAY DENTAL

HEALTH QUESTIONNAIRE

Answering these questions completely is for your benefit and assures your safety during treatment.

MEDICAL HISTORY

1. Are you now under the care of a physician? Condition treated:	YES	NO
2. Have you ever had a serious illness, operation or hospitalization?	YES	NO
3. Are you taking medications? What?	YES	NO
4. Have you ever used recreational drugs (e.g. marijuana, cocaine etc.)?	YES	NO
5. Have you ever been premedicated with antibiotics for dental treatment? What?	YES	NO
6. Do you use tobacco in any form? What and how much?	YES	NO
7. Have you ever taken the drugs "Phen-Phen"or "Redux"?	YES	NO
8. (Women) Are you pregnant? If so, when is the due date?	YES	NO

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

Cardiovascular System

Congestive Heart Failure	YES	NO
Heart Murmur	YES	NO
Heart Attack	YES	NO
Shortness of breath/Ankle swelling	YES	NO
Angina Pectoris	YES	NO
High Blood Pressure	YES	NO
Congenital Heart Disease	YES	NO
Mitral Valve Prolapse	YES	NO
Artificial Heart Valve	YES	NO
Pace Maker	YES	NO
Heart Surgery	YES	NO

Bone/Muscles

Arthritis/Rheumatism	YES	NO
Artificial Joints/Limbs	YES	NO
Taken Bisphosphonates in the past?	YES	NO

Urinary

Kidney Disease	YES	NO

Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO

Allergies to Medications

Latex	YES	NO
Penicillin	YES	NO
Clindaymycin	YES	NO
Sulfa Drugs	YES	NO
Codeine	YES	NO
Aspirin	YES	NO
Other_____	YES	NO

Blood

Bruise Easily	YES	NO
Anemia	YES	NO
AIDS/HIV	YES	NO

Respiratory

Asthma	YES	NO
Emphysema	YES	NO
Tuberculosis (TB)	YES	NO

Nervous System

Epilepsy/Seizures/Convulsions	YES	NO
Psychiatric Treatment	YES	NO
Stroke	YES	NO

Others

Glaucoma	YES	NO
Allergies/Hives	YES	NO
Ringing in the Ears	YES	NO
Radiation Therapy/Chemotherapy	YES	NO
Cerebral Palsy	YES	NO
Metal Allergies	YES	NO
Tumors or growths	YES	NO
Sinus Problems	YES	NO
Dizziness/Fainting	YES	NO

Digestive System

Hepatitis (Type:___)	YES	NO
Jaundice	YES	NO
Ulcers	YES	NO

10. Do you have any other medical issues not mentioned above?	YES	NO

East Bay Dental

DENTAL HISTORY

1. Do you have any discomfort, pain or concerns at this time?	YES	NO
Describe:		
2. Have you ever had any serious trouble with previous dental treatment?	YES	NO
Describe:		
3. Does dental treatment make you nervous? NO SLIGHTLY MODERATELY EXTREMELY		
4. Have you ever been treated for Gum Disease or Periodontal Disease?	YES	NO
If so, when?		
5. When were your last x-rays taken? Date:		
6. When was your last dental visit? Date:		
7. When was your last cleaning? Date:		
8. Have you ever had trouble with Local Anesthetic?	YES	NO
What happened?		

MOUTH

Bleeding, Sore Gums	YES	NO
Unpleasant taste/Bad breath	YES	NO
Swelling/lumps in mouth	YES	NO
Biting cheeks/lips	YES	NO
Have had Orthodontic treatment (braces)	YES	NO
Clicking/popping noises from jaw	YES	NO
Difficulty opening/closing jaw	YES	NO
Diagnosed with TMJ problem	YES	NO

TEETH

Loose teeth	YES	NO
Sensitive to hot	YES	NO
Sensitive to cold	YES	NO
Sensitive to sweets	YES	NO
Sensitive to biting	YES	NO
Food Impaction	YES	NO
Clenching/Grinding	YES	NO
Shift/Change in bite	YES	NO

PROSTHETICS

Full upper denture	YES	NO	How old?	Is it comfortable?	YES	NO
Full lower denture	YES	NO	How old?	Is it comfortable?	YES	NO
Partial upper denture	YES	NO	How old?	Is it comfortable?	YES	NO
Partial lower denture	YES	NO	How old?	Is it comfortable?	YES	NO

10. How often do you brush? NEVER ONCE DAILY TWICE DAILY AFTER EVERY MEAL		
11. How often do you floss? NEVER INFREQUENTLY DAILY AFTER EVERY MEAL		
12. Do you like the color of your teeth?	YES	NO
13. Would you be interested in a dental cosmetic consult with our doctors?	YES	NO

Patient/Guardian's Signature **X** _____ Date: _____

Reviewing Doctor: _____ Date: _____

Financial Responsibility

Although we will do our very best to verify patient eligibility, the ultimate responsibility for verifying and maintaining insurance eligibility with our dental office lies entirely with you the patient. Any procedures when the patient is not eligible with our office will be the patient's financial responsibility and will be billed to the patient at the full usual and customary rate. We do not accept retroactive eligibility. This policy applies to all patients in, but not limited to, the following situations: new patients; emergency patients; patients eligible one month but not the next because of change of job or personal status or any other reason; patients that forget they are no longer eligible patients who plead ignorance.

General Consent Form

I assign all dental benefits to which I am entitled to. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to East Bay Dental for dental services rendered to myself and/or my dependent(s) regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I hereby request and authorize the dentist and the staff of East Bay Dental to perform dental work upon me for the purpose of diagnosis and the improvement of the appearance, function and health of my mouth and its associated structures.

I understand it is my responsibility to ask questions and will not agree to any procedures to be done in my mouth unless I fully understand what is involved, the risks and benefits of the procedure and its alternatives.

I know and understand the practice of dentistry and surgery is not an exact science and those reputable dental practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that only the treating dentist is responsible for my dental treatment.

I certify that I have read and fully understand the above consent to the dental treatment. I have read the financial responsibility and cancellation policies and agree to abide by these policies.

_____ _____

Patient's Signature Date

East Bay Dental 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.

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 (4/13/2003), 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 applicable law permits changes. 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 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, 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 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 official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials 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 $0.50 for each page, $100.00 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 electronic mail (email), you are entitled to receive this Notice in written form.

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 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: Dr. Lawrence Wu

Telephone: 925-777-1719 Fax: 925-777-0911

Address: 5157 Lone Tree Way, Antioch, Ca 94531

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Antioch CA 94531

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____
Print Name

_____
Signature

_____
Date