



5094 N. Fruit Ave Ste 102  
Fresno, CA 93711

Phone: (559)221-6200  
Fax: (559)221-6206

## Patient Information

Patient's Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle initial)

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ (street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (zip)

Home Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Driver License # : \_\_\_\_\_ Social Security #<sup>1</sup>: \_\_\_\_\_

Type of Payment: ☐ Cash ☐ Denti-Cal ☐ Insurance

If patient is a minor, give name of Parent or Legal Guardian: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

You are referred by: \_\_\_\_\_

### In case of emergency:

Name of person we can contact: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

### Financially Responsible Person

Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer number/Human resource department #: \_\_\_\_\_

## Dental Insurance

### Primary Carrier-----

Insurance Company: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Employer: \_\_\_\_\_

Group #: \_\_\_\_\_

Employee Social Security # \_\_\_\_\_

Date of birth: \_\_\_\_\_

Work address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

### Secondary Carrier-----

Insurance Company: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Employer: \_\_\_\_\_

Group #: \_\_\_\_\_

Employee social security # \_\_\_\_\_

Date of birth: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

<sup>1</sup> We keep your social security confidential. It is used to verify insurance eligibility and filing insurance claim.

## Health History

These questions bellows are for your benefits and will assure that treatment will take into consideration your past and present health status. Please circle one answer for each question.

1. Has there been any change in your general health in the last year-----Yes/No
2. Are you now or have you recently been under the care of a physician?-----Yes/No

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

3. Are you currently taking any kind of **drugs** or **medicine**? -----yes/no  
If Yes, please list: \_\_\_\_\_

4. Are you allergic to anything? (Medicine, food, drug, **Latex etc.**)-----yes/no  
If Yes, Please list: \_\_\_\_\_

5. Have you ever had a problem with bleeding?-----yes/no

6. Have you been pre-medicated with antibiotics for your dental treatment?-----yes/no

7. Have you ever had any unfavorable reactions from dental or medical treatment?-yes/no

8. Have you ever had any of the following? Please circle Yes or No for each of the following

Heart failure-----yes/no

Rheumatic Fever-----yes/no

Heart disease/attack-----yes/no

Arthritis-----yes/no

Angina pectoris-----yes/no

Rheumatism-----yes/no

Congenital Heart Disease-----yes/no

Pain in Jaw Joints-----yes/no

Heart Murmur Active-----yes/no

Cortisone Medication-----yes/no

Arteriosclerosis-----yes/no

Psychiatric Treatment-----yes/no

Mitral Valve Prolapse-----yes/no

Stroke-----yes/no

Artificial Heart Valve-----yes/no

Artificial Joints-----yes/no

Heart Pacemaker-----yes/no

Epstein-Barr Virus-----yes/no

Heart Surgery-----yes/no

Kidney Troubles-----yes/no

☐ Ulcers

☐ Hay fever

☐ Hepatitis A

☐ Hemophilia

☐ Diabetes

☐ Allergies/Hives

☐ Hepatitis B

☐ H.I.V.

☐ Thyroid Problems

☐ Sinus Trouble

☐ Hepatitis C

☐ Liver Disease

☐ Glaucoma

☐ Radiation Therapy

☐ Chicken Pox

☐ Nervousness

☐ Emphysema

☐ Chemotherapy

☐ Cold Sores/Herpes

☐ Fear/Anxiety

☐ Chronic Cough

☐ Drug Addiction

☐ Venereal Disease

☐ Phen-fen

☐ Tuberculosis

☐ Special Diet

☐ Blood Transfusion

☐ Epilepsy

☐ Asthma

☐ Sudden Weight loss

☐ Anemia

☐ Seizures

☐ Yellow Jaundice

☐ Sickle Cell Disease

☐ Bruise Easily

☐ Brain injury

☐ High Blood Pressure

Are you taking any Bisphosphonates (for example Fosamax, Alendronate)-----Yes/No

Do you have osteoporosis-----Yes/No

9. Do you have any disease, condition, or problem not listed above?-----yes/no

If so, what?\_\_\_\_\_

10. (Female) Is it possible that you may be pregnant? If so, when is the baby due?----yes/no

Are you nursing?-----yes/no

Are you taking birth control pills?-----yes/no

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will inform my dentist at my next appointment.** I understand that antibiotics and analgesics and other medications can cause allergic reactions, causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reactions).

Date:\_\_\_\_\_ Signature:\_\_\_\_\_

Recall1

Changes in health:\_\_\_\_\_

Reviewed by:\_\_\_\_\_ BP:\_\_\_\_\_ Pulse\_\_\_\_\_

Date:\_\_\_\_\_ Signature:\_\_\_\_\_

Recall2

Changes in health:\_\_\_\_\_

Reviewed by:\_\_\_\_\_ BP:\_\_\_\_\_ Pulse\_\_\_\_\_

Date:\_\_\_\_\_ Signature:\_\_\_\_\_

Recall3

Changes in health:\_\_\_\_\_

Reviewed by:\_\_\_\_\_ BP:\_\_\_\_\_ Pulse:\_\_\_\_\_

Consent for treatment: I hereby authorize the dentist in charge of treatment to perform x-rays and other diagnostic aids appropriate to make a thorough diagnosis of the patient's dental needs and to administer such anesthetics, analgesics, or nitrous oxide sedation.

If the patient is a minor or if the patient is physically or mentally incompetent, I consent to agreed upon dental services. I guarantee payment in full for the above listed patient.

Signed:\_\_\_\_\_ Date:\_\_\_\_\_ Relationship to patient:\_\_\_\_\_

Provider signature:\_\_\_\_\_

## Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **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 barrier prohibited obtaining the acknowledgement
- (     ) An emergency situation prevented us from obtaining acknowledgement
- (     ) Other (please specify) \_\_\_\_\_

Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

---

## Our Office Policy

---

**Tsu Ping Chen, DDS Inc.**  
**5094 N. Fruit Ave Ste 102**  
**Fresno, CA 93711**  
**Phone: (559)221-6200 Fax: (559)221-6206**

**Payment:** Payment is expected at the time of service. Payment is accepted in cash, check, or credit card. Your Insurance will be billed with the information you provide. It is your responsibility to provide the appropriate billing information and to determine covered services through your individual dental plan. We are required by insurance contracts to collect any co-payment or deductible due on the date of service.

**Out of Pocket Expenses:** The following services are not covered by insurance

Late Fee (on balance over 30 days)	\$25 per month
Missed appointment (cancelled in less than 24 hours without notice)	\$60
Returned check	\$30
Dental records request (No charge to requesting dental provider)	\$25
Medi-Cal Denti-Cal copayment <sup>2</sup> per visit	\$1
Medi-Cal Denti-Cal Prescription copay	\$1

**Cancellations:** If you are unable to keep your appointment, please call our office at least 24 hours prior to your appointment in order to reschedule. If you fail to keep an appointment without canceling at least 24 hours in advance, you will be charge \$60. This charge will not be covered by your insurance. If you continue to miss appointments, you will be dismissed from the practice.

**Trust** between patient and dentist is the most important relationship before any dental treatment. For example, you trust us to provide you with honest, genuine care, and we trust you to show up on time to your appointment and to be compliant to recommended dental treatment.

I have read and agree to these policies, understand the notice to consumers and have had the opportunity to receive a copy of the office policy.

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

---

<sup>2</sup> See California Medi-Cal Dental Services Beneficiary Handbook Online for copayment criteria. P.15

## **Notice of Privacy Practices**

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**Privacy Officer: Cruz Silva**

**Dental Office: Tsu Ping Chen, DDS Inc. 5094 N. Fruit Ave Ste 102 Fresno CA 93711**

**Effective Date: 06/19/2018**

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the privacy officer at this practice.

### **Who will follow this Notice**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### **How we may use and disclose medical information about you**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

#### **For Treatment.**

We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

#### **For Payment.**

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

## **For Health Care Operations.**

We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

## **Other Uses or Disclosures That can be made without consent or Authorization**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

## **Use and Disclosures of Protected Health Information Requiring Your Written Authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

## **Your Individual Rights Regarding Your Medical Information**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Rights to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is

involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

### **Right to Request Confidential Communications.**

You have the right to request how we should send communications to you about medical matters, would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

### **Right to Inspect and Copy.**

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

### **Right to Amend.**

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request



should indicate in what form you want the list (examples: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.**

You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

**Changes to This Notice**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.