Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: M / F Family Status: (please circle) Single, Married, Widowed, Divorced

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cellular): _____

E-Mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

In case of emergency who should be notified ? _____ Phone _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies to Medicines
  _____
  _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Allergic to Latex

Pregnancy
Due date:_____

- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Current Medicine:
- ☐ _____
- ☐ _____
- ☐ Herbal Medicine and Supplements:
- ☐ _____
- ☐ _____

OTHER/ Vitamins

- ☐ _____
- ☐ _____
- ☐ Bisphophonate (Fosamax)

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____ Provider Signature:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is a insured patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is a insured patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

DRAGON
DENTAL GROUP

1808 Franklin Street
Oakland, CA 94612
Phone: (510) 268-1727
Fax: (510) 268-3573

www.DragonDental.com

Scheduling Policy

Trying to accommodate every patient's individual needs and work schedules can be difficult. But we do our best. We work very hard to stay on schedule so as to minimize your waiting time in our office.

A scheduled appointment is a commitment of time between the Doctor and the patient. We have reserved that time JUST FOR YOU. When appointments are missed or cancelled, the time is lost.

We ask that when you schedule your treatment, you make every effort to keep that commitment. We understand that personal emergencies do arise, and we always take that into consideration.

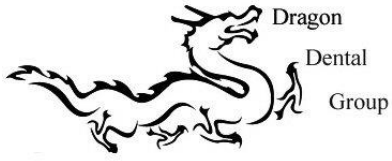
But if you cannot keep your scheduled appointment, a **48** hour notice will allow us to schedule another patient in need of treatment.

It is now our policy that with less than 48 hours notice on a change of commitment, a charge will be considered of $80, and could be applied to your account.

If you have any questions regarding this or any of our policies or procedures, as always, we are more than happy to discuss them with you.

Thank you for your understanding and cooperation.

Signed _____ Date _____
Best Contact #_____ Best time to Call:_____



DENTAL FINANCIAL POLICY

Direct Payment

The following financial policy applies to all patients who will be paying for their own care. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

You can choose from 3 different methods of payment.

1. Pay in Advance

Pay in full for your treatment program and receive a 5% discount on the total amount. Collecting money owed from insurance companies or patients takes a considerable amount of time and expense. We have found it easier and less expensive when patients pay in advance. We can then pass the savings on to you. You can pay with cash, a check, American Express, Discover, MasterCard or VISA.

2. Arrange Financing with Care Credit

Through a special arrangement with Care Credit, you may pay for your treatment program with six monthly payments with no interest. Ask for the necessary paperwork.

3. Pay As You Go

Pay for each individual service or phase of service before receiving the treatment. You can pay with cash, a check, American Express, Discover, MasterCard or VISA.

We are very happy you chose us for your dental care. We will do all we can to help you achieve optimum dental health. Please let any of us know of any way we can better serve you.

By signing below you agree to follow this policy.

SIGNED:

_____ _____

Patient Name **Date**

_____

Patient Signature

_____ _____

Staff Print Name **Date**

_____

Staff Signature

Dragon Dental Group

DENTAL FINANCIAL POLICY

Insurance Coverage

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement providing you agree with it. Let our finance staff knows if you have any questions.

1) **We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, remember that paying for your treatment is your personal responsibility. We will verify your insurance benefits by contacting the insurance company. You will need to sign an AAssignment of Rights and Benefits@ so we can accept your insurance coverage.**

2) **You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment, and charges your insurance company refuses to pay. While our office policy does not allow us to extend credit, we can automatically debit your American Express, MasterCard or VISA card for these charges.**

Until we have verified your coverage, you will be responsible for paying for your own care at each visit including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill. Using your credit card for this purpose will be the easiest for you.
For the payment which is due today, which payment method do you prefer?

☐ Cash/Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

3) **Once your insurance payment has been received, or sixty days after treatment, whichever occurs first, your account will be balanced. We will either owe you a refund or you will owe us a payment.**

If you have a refund due, how would you like us to handle it?

☐ Apply the refund to my account for future treatment.
☐ Reimburse the refund to my Credit Card.

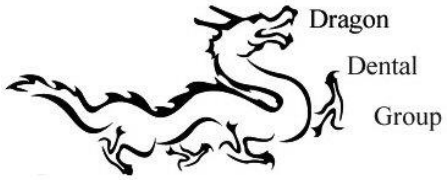
If your insurance company does not pay or if you owe us an additional payment, we will notify you and ask for payment upon requested.

4) **Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important. Also, your insurance company may request additional information from you. They will not pay your claim until they receive the information, so please send it immediately.**

5) **If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by your insurance company will become immediately due and payable by you personally before you leave or will automatically be charged to your credit card.**

By signing below you agree to the terms of this policy.

_____	_____	_____
Patient Name	**Signature**	**Date**
(Parent/guardian if patient is a minor)		
_____	_____	_____
Staff Member Name	**Signature**	**Date**



Assignment[1] of Rights and Benefits

Patient Name _____ Insurance Company _____

Policy Holder's Name _____ Claim/Group Number _____

Employer _____ SS Number/ID Number _____

I hereby assign all rights and benefits under my contract with my dental insurance company to Dr. Joyce Tse for the purpose of determining the details of the benefits of this policy and obtaining payment for services given.

This assignment further permits Dr. Joyce Tse to obtain from my dental insurance company all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Dr. Joyce Tse of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

This assignment shall allow Dr. Joyce Tse to take all action necessary to obtain the benefits I have, in good faith, been promised by my dental insurance company. All benefits are to be paid directly to Dr. Joyce Tse at 1808 Franklin Street, Oakland, CA 94612.

If my current policy prohibits direct payment to Dr. Joyce Tse, then I hereby also instruct and direct you to make out the check to me and mail it care of Dr. Joyce Tse at 1808 Franklin Street, Oakland, CA 94612.

A photocopy of this assignment shall be considered as effective and valid as the original.

Assignment means "to give." This form means you are giving this office full authorization to act on your behalf in obtaining information and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments and any amounts the insurance company will not pay.

I further authorize Dr. Joyce Tse to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf.

This assignment shall remain in effect for the duration of treatment and any additional time necessary to secure full payment for services rendered.

This is a direct assignment of my rights and benefits under this policy.

Signed:

_____	_____	_____	_____
Policy Holder Signature	Date	Staff Signature	Date

_____	_____
Patient (if other than Policy Holder)	Date

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices provides a complete description *of* the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice *of* Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

_____

Signature *of* Individual or Legal Representative Witness

_____

Printed Name of Individual or Legal Representative

Witness..... ..... Date:..... FOR

OFFICE USE ONLY

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

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

_____

_____

_____ _____

HIPAA Officer Date

Consent and Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

(Revised March 2013)

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.
- *I have the right to restrict disclosure of PHI to a health plan with respect to treatment for which the individual has paid fully out-of-pocket.*

_____

Signature of Patient or Legal Representative Witness

_____ _____

Printed Name of Patient or Legal Representative Witness Date

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative regarding:

• All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

• Only the following types of information:

The above medical information shall only be released to the following persons:
Family Member / Personal Representative Relationship

_____ _____

_____ _____

_____ _____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)
• Until revoked in writing.
• Until_____, 20____

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature _____

Signed this_____day of_____, 20_____