PATIENT INFORMATION

Name Last	First	M.I.	SS#	Sex M / F	DOB / /	Age
Street Address		City	State	Zip Code		
Whom may we thank for referring you to our practice?						
If the patient is a minor, please give parent's/guardian's name.						

RESPONSIBLE PARTY INFORMATION

Name Last	First	M.I	SS#	DOB	Relationship To Patient	
Street Address (if different from above)		City		State	Zip Code	
How long at this address?	Previous Address (if less than 3 years)					
Home Phone	Work Phone		Mobile Phone	Email		
Employer			Occupation	# Years Employed		
Business Address		City		State	Zip Code	
Spouse's Last	First	M.I.	SS #	DOB	Relationship To Patient	
Employer			Occupation	# Years Employed		
Business Address		City		State	Zip Code	
Home Phone (if different)	Work Phone		Mobile Phone	Email		
Street Address (if different)		City		State	Zip Code	

INSURANCE INFORMATION

Insured Name Last	First		SS #
Insurance Co.		Group #	Local #
Insurance Co. Address		State	Zip Code
If you have dual insurance coverage, please give additional information			
Insured Name Last	First		SS #
Insurance Co.		Group #	Local #
Insurance Co. Address		State	Zip Code

EMERGENCY INFORMATION

Name Of Nearest Relative Not Living With You			
Home Address	City	State	Zip Code
Work Address	City	State	Zip Code
Home Phone	Work Phone		

I understand that when appropriate, my credit reports may be obtained to extend credit.

Signed (Parent/Guardian if minor) _____ Date: _____/_____/_____

Orthodontics for Adults and Children

ADULT HEALTH HISTORY

Peter Lee
DDS, MS, BDS (Lond), LDSRCS Eng

Today's Date: _____

Patient's Name *Last* _____ *First* _____ **Birth Date** _____

Whom may we thank for referring you? _____

Physician _____ **Physician's** _____ **Date of Last Medical Visit** _____

Physician's Address _____

Dentist _____ **Dentist's Phone** _____ **Date of Last Dental Visit** _____

Dentist's Address _____

Reason for this Orthodontic Visit _____

	Yes	No
1. Do you have a health problem?	O	O
2. Are you being treated for any medical problem now?	O	O
If yes, for what? _____		
3. Are you taking any medication?	O	O
If so, what? _____		
4. Have you ever been a patient in a hospital?	O	O
If yes, why? _____		
5. Have you ever received general anesthesia or surgery?	O	O
6. Have you ever had had a blood transfusion?	O	O
7. Are you allergic to anything, medicine, food, latex, metal, etc.?	O	O
Please list _____		

Reviewer Comments

8. Have you ever been diagnosed to have any of the following conditions or problems?

Yes	No		Yes	No		Yes	No	
O	O	Abnormal Bleeding/Hemophilia	O	O	Diabetes	O	O	Hepatitis, Type ___
O	O	ADHD/Learning Impairment	O	O	Diphtheria/Whooping Cough	O	O	Jaundice
O	O	AIDS/HIV	O	O	Drug/Alcohol Abuse	O	O	Kidney
O	O	Anemia	O	O	Drug Reaction	O	O	Leukemia/Lymphoma
O	O	Arthritis/Joint Disease	O	O	Ear	O	O	Liver
O	O	Asthma	O	O	Emotional/Psychiatric	O	O	Rheumatic Fever
O	O	Autism	O	O	Emphysema/Lung	O	O	Scarlet Fever
O	O	Autoimmune	O	O	Endocrine	O	O	Sickle Cell Anemia
O	O	Blood Pressure	O	O	Eye/Vision	O	O	Skin
O	O	Bone	O	O	Fainting	O	O	Sleep Apnea/Snoring
O	O	Brain Injury/Stroke	O	O	Gastrointestinal	O	O	Smoking/Tobacco Use
O	O	Cancer/Tumor	O	O	Headaches	O	O	Specific Syndromes
O	O	Chemotherapy/Radiation	O	O	Hearing	O	O	Spina Bifida
O	O	Chicken Pox	O	O	Heart Disease	O	O	Tonsils/Adenoids
O	O	Cleft Lip/Palate	O	O	Heart Murmur	O	O	Tuberculosis
O	O	Convulsion/Epilepsy/Seizures	O	O	Heart Valve/Pacemaker	O	O	Venereal Disease/STD

9. Is there anything else we should know about you? _____

DENTAL HISTORY

10. Do you have any of the following?

Yes	No		Yes	No	
O	O	Finger or Thumb Habit	O	O	Are you happy with your smile?
O	O	Tongue Thrust or Mouth Breathing	O	O	Do you like the arrangement of your teeth?
O	O	Dentist Extracted One or More Tooth/Teeth	O	O	Do you have any speech impediment?
O	O	Previous Injury to Face, Head, Jaw, or Teeth	O	O	Have you had orthodontic treatment before?
O	O	Extra or Missing Permanent Tooth/Teeth	O	O	Have you had an orthodontic consultation prior to this visit?
O	O	Previously Extracted Wisdom Teeth			If so, with whom and when? _____

TMJ / JAW JOINT HISTORY

11. Do you have any of the following?

Left	Right	None		Yes	No	
O	O	O	Clicking, Noise, or Popping of the Jaw Joint/s	O	O	Clenching of the Mouth
O	O	O	Discomfort or Pain of the Jaw Joint/s	O	O	Grinding of the Teeth
O	O	O	Discomfort or Pain with the Facial and Neck Muscles	O	O	Locking of the Jaw
O	O	O	Difficulty in Closing or Opening of the Jaw	O	O	Frequent Headaches (more than 1 headache/week)
O	O	O	Feeling of Teeth that do not meet comfortably	O	O	History of Previous use of Splint, TMJ, or Jaw Joint Appliances

I certify that I have read and understood all questions. I will not hold Dr. Peter Lee or any member of his staff responsible for any errors or omissions I may have made in completing this form. I authorize release of may information related to insurance claim, and I consent to examination by Dr. Peter Lee. I also authorize payment of any insurance benefits to the practice. I shall inform the practice of any future health or medical changes to the practice.

Signature of Patient: _____ Date: _____

REVIEWED MEDICAL HISTORY

To be completed by staff.

Name and Initial: _____ Date: _____

NOTES

Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you 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 discloses we may make of your protected health information, and of other important matters about your protected health information. A copy of our notices accompanies this consent. We encourage you to ready 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 all changes. This may apply to any of your protected health information that we maintain.

Right to Revoke: You have the right to revoke this consent at any time by providing a written notice of your revocation. Please note that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decide to treat you or discontinue to treat you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I further acknowledge I have received a copy of your Notice of Privacy Practices.

Patient's Name: _____ Patient's DOB: _____

Signature: _____ Today's Date: _____

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

Representative's Name: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____, acknowledge that I have reviewed the Dental Materials Fact Sheet of the California Dental Association.

Patient's Name: _____ Patient's DOB: _____

Signature: _____ Today's Date: _____

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

Representative's Name: _____ Relationship: _____

FOR PRACTICE USE ONLY

We attempted to obtain written acknowledgement and consent of our Notice of Privacy Practices and Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

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

Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

GENERAL PRACTICE INFORMATION & FINANCIAL POLICY

Thank you for choosing **Orthodontics Pediatric Dentistry San Francisco** as your child(ren)'s dental home. We promise to provide you with excellent care and treat you with compassion and integrity. As we work together, kindly note the following general practice information and financial policy:

Hours of Operation: Our business hours are Monday through Friday from 8:00AM to 5:00PM and two Saturdays a month from 8:00AM to 4:00PM. We are closed for major holidays. We offer after hour emergency care. Please call our office to be directed to the doctor on-call.

New Patient Appointment: At each New Patient Visit, your child will receive a comprehensive examination, a dental cleaning and a topical fluoride treatment. Sometimes when the child is very young, the cleaning or fluoride treatment may not be indicated.

Radiographs (x-rays): Selected dental x-ray is recommended on an individually basis depending on the risk assessment for dental decay and gum disease as well as history of dental injuries.

Routine Dental Checkups: Check-up visits are generally scheduled 6 months ahead; some are every 3-4 months depending on your child's needs. At each check-up, your child will receive an examination, cleaning, fluoride treatment, and radiographs as needed.

Dental Treatment: If your child requires any treatment, it will be discussed with you. Upon your consent you will need to sign the treatment plan before treatment is rendered. There may be additional consent forms depending on the type of dental procedure.

Minor Consent: If a parent/legal guardian is unable to accompany the child to an appointment, we ask that you sign the Minor Consent Form ahead of time. This form can be obtained from our front office or on our website, www.opdsf.com.

Cancellation/Failed Appointment Fees: Each appointment visit is specially reserved for you and your child. We send appointment reminders via email, text and by phone. We ask that you give us a 48-hour notice if you need to cancel of reschedule. We reserve the right to charge $60 for any late cancellation or failed appointment.

Patient Co-payments/Deductibles: As parent/legal guardian/guarantor, you are responsible for the cost of any treatment not covered by your dental benefits. The estimated copayment is due at the time of service. Sometimes insurance companies pay on a lower fee schedule. We will bill or refund you the difference after your insurance makes the final payment. We ask payment be submitted within 30 days unless a financial agreement has been made with our practice.

Accurate Insurance Information: To help file your insurance claims we ask that you provide us with accurate and updated dental benefits information so that your claims can be processed in a timely manner.

Out-of-Network Plans: For some out-of-network PPO plans that pay subscribers directly, we will require full payment from you at the time of service.

Past Due Accounts / Returned Check Fees: There is 3% monthly interest rate on any balance past 30 days, and a $30 fee for any returned check. Financial arrangement may be made on an individual basis.

By signing this document, I agree to comply with OPDSF's general practice information and financial policy. I understand I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I am also authorizing the payment of dental and medical benefits to Dr. Dorothy Pang, and for her practice to release all information necessary to secure all payment. The assignment of benefits will remain effective until I revoke it in writing. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. A photocopy of this assignment is considered to be as valid as an original.

Name of parent/legal guardian/responsible party: _____

Signature: _____ Date: _____

Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect _____ and will remain in effect until we replace it.

◯ _____ (Initial)

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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

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

Treatment

We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment

We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations

We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 your 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 health care. 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.

Notice of Privacy Practices (continued)

Marketing Health-Related Services
We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

_____ _____

Signature of Patient/Parent/Legal Guardian Name of Patient/Parent/Legal Guardian

_____

Relationship to patient (Self/Parent/Legal Guardian)