

PATIENT INFORMATION

West Coast Oral Surgery

(Mr., Mrs., Ms., Dr.) First Name: _____ M.I. _____ Last Name: _____
 Sex: () Male () Female Date of Birth: _____ Age: _____ Social Security Number: _____
 Street: _____ Apt./Suite# _____ City: _____ State: _____ Zip: _____
 Home Tel. () _____ Bus. Tel. () _____ Ext: _____ Mobile: () _____
 Driver's License# _____ Driver's Lic. State: _____ Occupation: _____
 E-Mail Address: _____
 Primary Dentist: _____ Referred By: _____ Primary Physician: _____

If someone else is responsible for your account, please complete:

Who will be responsible (guarantor) for your account? Relation: () Spouse () Mother () Father () Other _____
 Name: _____ DOB: _____ Home Tel: () _____ Mobile: () _____
 Street: _____ City: _____ State: _____ Zip: _____ Employer: _____
 Bus. Tel: () _____ Social Sec.# _____ Driver's Lic.# _____ Driver's Lic. State: _____

In case of **EMERGENCY**, contact: _____ Relationship to Patient: _____
 Home Tel. () _____ Work Tel.() _____ Mobile Phone: () _____

INSURANCE COMPANY INFORMATION (to assist in utilizing your insurance benefits, please be thorough as possible):

	The information below is required if you do not have your insurance card(s) with you.	The information below is required if the primary subscriber is different than the guarantor above or if there is a secondary subscriber.
Primary Dental Insurance	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Group# _____ Employer Name: _____ START DATE OF PRIMARY INS.: _____	Primary Subscriber: _____ Relationship to Patient: () Spouse () Father () Mother () Stepfather () Stepmother () Other _____ Date of Birth: _____ Phone: () _____ Social Security# _____ or Subscriber ID# _____
Secondary Dental Insurance	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Group# _____ Employer Name: _____ START DATE OF SECONDARY INS.: _____	Secondary Subscriber: _____ Relationship to Patient: () Spouse () Father () Mother () Stepfather () Stepmother () Other _____ Date of Birth: _____ Phone: () _____ Social Security# _____ or Subscriber ID# _____
Medical Insurance	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Group# _____ Employer Name: _____	Primary Subscriber: _____ Relationship to Patient: () Spouse () Father () Mother () Stepfather () Stepmother () Other _____ Date of Birth: _____ Phone: () _____ Social Security# _____ or Subscriber ID# _____

FEES AND PAYMENTS: We make every effort to help you manage the costs of your oral surgical care. You can assist by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you. If you have any dental and/or medical insurance, we will be able to complete the proper insurance forms as a courtesy to you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, coinsurance, co-pays, estimated patient portion, or any other balance not paid for by your insurance carrier upon delivery of service.**

This signature on file is my authorization for the release of any information necessary to process my claim. I hereby authorize payment directly to the doctor named on the insurance benefits otherwise payable to me. I agree to pay all reasonable costs and attorney's fees, if I do not pay any of the bills incurred.

Signature of Patient or Legal Guardian Representing Patient (Guarantor): _____ **Date:** _____

Patient's Name: _____ Age: _____ Date: _____

Please indicate YES or NO if you have or had any of the following:

YES NO	YES NO	YES NO
<input type="radio"/> Recent illness (within 1 year)	<input type="radio"/> Irregular heartbeat/palpitations	<input type="radio"/> Thyroid disease
<input type="radio"/> Cough, cold or flu (recent)	<input type="radio"/> Heart murmur	<input type="radio"/> Seizures or epilepsy
<input type="radio"/> Nasal obstruction	<input type="radio"/> Rheumatic fever	<input type="radio"/> Psychiatric treatment
<input type="radio"/> Loud Snoring	<input type="radio"/> Scarlet fever	<input type="radio"/> Liver disease
<input type="radio"/> Difficulty opening mouth / TMJ	<input type="radio"/> High blood pressure	<input type="radio"/> Cirrhosis of the liver
<input type="radio"/> Lung disease	<input type="radio"/> Blood vessel grafts	<input type="radio"/> Jaundice
<input type="radio"/> Shortness of breath	<input type="radio"/> Heart surgery	<input type="radio"/> Hepatitis
<input type="radio"/> Asthma	<input type="radio"/> Stroke	<input type="radio"/> Stomach ulcer
<input type="radio"/> Bronchitis	<input type="radio"/> Arthritis	<input type="radio"/> Diabetes
<input type="radio"/> Emphysema	<input type="radio"/> Artificial joints	<input type="radio"/> Kidney Disease
<input type="radio"/> Tuberculosis (TB)	<input type="radio"/> Cortisone or steroid use	<input type="radio"/> HIV+ / AIDS
<input type="radio"/> Heart failure	<input type="radio"/> Extensive bleeding	<input type="radio"/> Osteoporosis
<input type="radio"/> Chest pain	<input type="radio"/> Anemia	<input type="radio"/> Other _____
<input type="radio"/> Heart attack	<input type="radio"/> Treatment for tumor or cancer/radiation	_____

Antibiotic and pain medications can alter the effectiveness of birth control pills. Use another method of birth control for the remainder of the menstrual cycle while taking antibiotics or pain medications. (If this applies to you, please initial: _____)

YES NO
<input type="radio"/> Are you in good health?
<input type="radio"/> Are you having pain or discomfort at this time?
<input type="radio"/> Have you had a bad experience with previous dental or surgical treatment?
<input type="radio"/> Have you been under the care of a physician or hospitalized during the past two years? If yes for what? _____
<input type="radio"/> Have you ever gone to sleep for an operation? If yes for what? _____
<input type="radio"/> Have you had any complications from anesthesia or previous surgery? If yes please describe: _____
<input type="radio"/> Have any family members had a serious reaction to a general anesthetic?
<input type="radio"/> Are you taking any medications? Please list (include over the counter medications, products with aspirin or ibuprofen, vitamins, birth control pills): _____
<input type="radio"/> Have you ever taken weight loss medication or any herbal or homeopathic supplements (e.g. vitamin E or fish oil)? _____
<input type="radio"/> Have you or do you currently take any medications for osteoporosis or bone cancer such as Fosamax, Boniva, Actonel, Reclast, Aredia, Zometa, Didronel or Skelid? _____
<input type="radio"/> Have you used recreational drugs during the last year? Please list as they can be dangerous in conjunction with anesthetic drugs: _____
<input type="radio"/> Do you smoke or chew tobacco? If yes, how long? _____ If you smoke, how many packs a day? _____
<input type="radio"/> Are you pregnant? If yes, how many months? _____
<input type="radio"/> Do you wear dentures or partials?
<input type="radio"/> Do you wear contact lenses?
<input type="radio"/> Do you have trouble swallowing pills?

Please indicate if you have allergies of any type, including allergies to soy or soy products, milk or milk products, or latex:

YES NO	YES NO
<input type="radio"/> Penicillin / ampicillin / amoxicillin	<input type="radio"/> Aspirin
<input type="radio"/> Novocain - local anesthetics - epinephrine	<input type="radio"/> Barbiturates
<input type="radio"/> Codeine	<input type="radio"/> Other drugs/medications/foods/materials: _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health status, or if my medications change, I will inform the doctor accordingly.

Patient's or legal guardian's signature: _____ Date: _____

If patient is a minor, please indicate relationship to patient: _____

For Office Use Only

Date: _____	BP: _____	Pulse: _____	Resp: _____	Weight: _____	Ht: _____	ASA: _____	Reviewed by: _____
Date: _____	BP: _____	Pulse: _____	Resp: _____	Weight: _____	Ht: _____	ASA: _____	Reviewed by: _____



West Coast Oral Surgery
Andrew K. Chang, M.D., D.D.S.

We would like to take this opportunity to welcome you and to thank you for choosing our office for your oral surgery needs.

Your appointment is scheduled on _____ at _____. Please arrive 15 minutes prior to your appointment time for patient registration.

Please complete both sides of the registration/health history form in its entirety and bring the form with you to your initial visit. Please have all of your insurance information and a copy of your insurance card(s) with you as well. Please also provide a copy of the driver's license of the person who is financially responsible for your account (guarantor). Providing us with this information will enable us to serve you better.

Check list of items to bring with you to your appointment:

- Copy of insurance card (dental and medical)
- Copy of guarantor's driver's license (the guarantor is the person financially responsible for your account).
- Completed registration/health history form
- Treatment request (referral form) from your referring dentist if available.
- If your referring dentist provided you with any x-rays pertaining to your treatment, please do not forget to bring the x-rays with you.
- Please note: We do not accept Dental HMO plans, Medi-Cal, Denti-Cal, Medicare, or Tricare Medical. Our office also does not participate with any medical insurance plans.

We thank you for your cooperation, and we look forward to making your experience with us a positive one.

Sincerely,

Dr. Andrew K. Chang and Staff

Please visit us online at www.westcoastoralsurgery.com for information about our doctor, office, staff and the services that we offer.

West Coast Oral Surgery
Fee Agreement and Information About Insurance
(Please Read Thoroughly)

Patient Name: _____

Guarantor (person financially responsible): () self () father () mother () other: _____

Your pre-treatment estimate contains information about the procedures that have been recommended to you by your doctor and the approximate costs of those procedures. The actual costs of the procedures recommended to you may be more or less depending on a variety of factors that include but are not limited to findings during surgery, materials used, and length of surgery. We make every effort to predict your surgical outcome so that your pre-treatment estimate is as accurate as possible.

Utilization of insurance benefits to cover the costs of services rendered can be a very complex process. It is important for patients to understand that an insurance plan is a contract between the patient and the insurance company and that payment for services rendered is ultimately the patient's responsibility. Therefore, it is very important for the patient to fully understand the rules of their insurance policy and what their insurance policy will and will not cover prior to having any procedures performed. Because the process of utilizing insurance benefits can be complicated, our office will assist you in every way possible to clarify your insurance coverage and to maximize your insurance benefits. In most cases, it is impossible to determine exactly what your insurance plan will cover at the time of your consultation without a predetermination of benefits from your insurance company. That being said, a predetermination of benefits does not always guarantee payment from your insurance company.

Depending on your insurance plan, a 10% - 40% down payment (your estimated portion) is payable on the date of surgery. We will bill your insurance for the date(s) of service for the amount billed to you. Depending on your coverage, plan limitations, deductible, or use of your yearly maximum, you may or may not have a remaining balance after your insurance has paid their portion. If for any reason your insurance fails to pay their portion within 90 days, the balance due will be your responsibility. If your insurance pays their portion and this leaves a credit balance on your account, you will receive an appropriate refund from our billing office within 4 weeks of insurance payment. You will receive a monthly statement from our office keeping you apprised of your account status until your account is paid in full.

For patients without insurance, full payment is requested on the date of service; however, financial arrangements can be made if needed. If you do not provide us with a current and valid copy of your insurance card(s) you will be considered a cash patient and payment will be due at the time of service.

Many procedures performed in our office are elective in nature. These procedures include but are not limited to dental implants, bone grafts, and cosmetic and reconstructive facial surgery. Although certain elective procedures may be necessary for your overall health and well being, insurance companies, in general, offer very limited or no coverage for these types of procedures. Patients should be fully prepared to accept financial responsibility for elective procedures.

Our office does not contract with or bill medical insurance, including but not limited to: Medicare, Medi-Cal, Denti-Cal, Blue Cross, Blue Shield, Tricare (medical only), or Obamacare insurance. We do not accept Workman's comp, nor do we accept any HMO or DHMO policies. Our office is not a provider for any medical insurance carrier. We do not accept personal checks over \$500.00. All major credit cards are accepted.

By signing below, you are indicating that you are the responsible party and the guarantor for either your account or this patient's account and that you have fully read and that you fully understand and agree to the above.

Signature of Responsible Party

Printed Name

Date



9855 Erma Road Suite 100 • San Diego, CA 92131 • t: (858) 536-2900 • f: (858) 271-0529 • drchang@westcoastoralsurgery.com

Date: _____

Patient's Name: _____ Referred by Dr. _____

xrays: with patient mailed e-mailed please take
xrays may be e-mailed to: help@westcoastoralsurgery.com

Reason for Referral:

- extraction(s)
- dental implants
- bone graft augmentation
- socket / sinus lift
- general anesthesia
- soft tissue surgery
- pathology
- orthognathic surgery

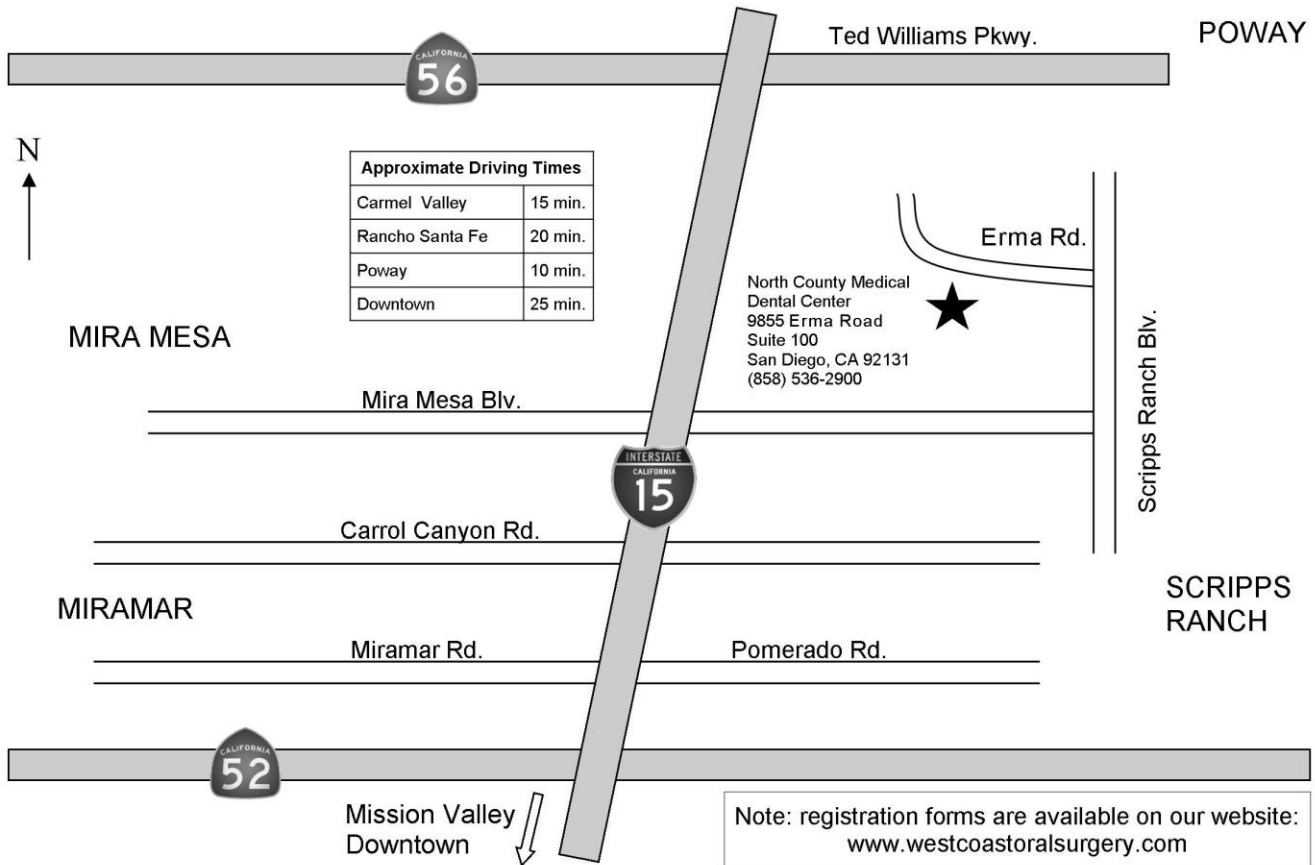
please circle area of concern

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
				A	B	C	D	E	F	G	H	I	J			
R				T	S	R	Q	P	O	N	M	L	K			L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Remarks: _____

For patients having GENERAL ANESTHESIA:

1. Do not eat or drink ANYTHING 8 hours before your appointment.
2. Bring someone with you who can stay during the surgery, take you home, and stay with you afterwards.



West Coast Oral Surgery

Notice of Privacy Practices for Protected Health Information

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.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact a member of our front office staff, in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact a member of our front office staff.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Chang or Dr. Cutri. You may also file a complaint by mailing it to the Secretary of Health and Human Services:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

This notice is available on our website: www.westcoastoralsurgery.com.

I, _____, hereby acknowledge that I have received a copy of this practice’s Notice of Privacy Practices, and that I fully understand the contents of this Notice. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature

Date

Notice Effective Date: 12/01/2009