PATIENT INFORMATION ***West Coast Oral Surgery***

(Mr., Mrs., Ms., Dr.) **First Name:** ________________________ M.I.______ **Last Name:** __________________________

Age: ______ Date of Birth: _______________ Sex: ( ) Male ( ) Female Social Security #: _______________________

Street: ___________________________________ Apt #_______ City: ____________ State: _____ Zip: _________

Home Tel. ( ) __________________ **Mobile**: ( ) __________________ ***PLEASE NOTE ~ reminders will be***

E-MAIL Address____ ***emailed and texted unless opted out***

Driver's License #: ____________________ Driver's License State: _______ Occupation: _______________________

Primary Dentist: _____________________ Referred By: _________________ Primary Physician: ______________

If someone else is responsible for your account *or making your appointments*, please complete:
Who will be responsible (guarantor) for your account? Relation: ( )Spouse ( )Mother ( )Father ( )Other _________________
Name: _____________________ DOB: ___________ Home Tel: ( )____________ **Mobile**: ( )______________
Street:_______________________________________ City:______________ State:_______ Zip:________________
E-MAIL:______ ______________________________ Social Sec.#_______________________
Driver's License #____________________ Driver's License State: _________ Employer: _________________________

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 charges** 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:**___________

Health Care Questionnaire: CONFIDENTIAL **West Coast Oral Surgery**

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	
O	O Recent illness (within 1 year)	O	O Irregular heartbeat/palpitations	O	O Thyroid disease
O	O Cough, cold or flu (recent)	O	O Heart murmur	O	O Seizures or epilepsy
O	O Nasal obstruction	O	O Rheumatic fever	O	O Psychiatric treatment
O	O Loud Snoring	O	O Scarlet fever	O	O Liver disease / cirrhosis
O	O Difficulty opening mouth / TMJ	O	O High blood pressure	O	O Alcoholism / drug abuse
O	O Lung disease	O	O Blood vessel grafts	O	O Jaundice
O	O Shortness of breath	O	O Heart surgery	O	O Hepatitis
O	O Asthma	O	O Stroke	O	O Stomach ulcer
O	O Bronchitis	O	O Arthritis	O	O Diabetes
O	O Emphysema	O	O Artificial joints	O	O Kidney Disease
O	O Tuberculosis (TB)	O	O Cortisone or steroid use	O	O HIV+ / AIDS
O	O Heart failure	O	O Extensive bleeding	O	O Osteoporosis
O	O Chest pain	O	O Anemia	O	O Other________________________
O	O Heart attack	O	O 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
- O O Are you in good health?
- O O Are you having pain or discomfort at this time?
- O O Have you had a bad experience with previous dental or surgical treatment?
- O O Have you been under the care of a physician or hospitalized during the past two years? If yes for what?
  ____
- O O Have you ever gone to sleep (deep sedation or general anesthesia) for an operation? If yes for what?
  ____
- O O Have you had any complications from anesthesia or previous surgery? If yes describe:
  ____
- O O Have any family members had a serious reaction to a general anesthetic?
- O O Are you taking any medications? Please list (include over the counter medications, products with aspirin or ibuprofen, vitamins, birth control pills, CBD/THC products):____
- O O Have you ever taken weight loss medication or any herbal or homeopathic supplements (e.g. vitamin E or fish oil)? ____
- O O 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?
  ____
- O O Have you used recreational drugs during the last year? Please list as they can be dangerous in conjunction with anesthetic drugs:____
- O O Do you smoke or chew tobacco? If yes, how long?________________ If you smoke, how many packs a day?_________
- O O Have you vaped?How often ________ last date of use _______ type: (circle all apply) tobacco marijuana/THC CBD
- O O Are you pregnant? If yes, how many months?_________________
- O O Do you drink alcoholic bevarages? If so, how many drinks do you consume per week? _________________
- O O Do you wear dentures or partials?
- O O Do you wear contact lenses?
- O O 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	
O	O Penicillin / ampicillin / amoxicillin	O	O Aspirin
O	O Novocain - local anesthetics - epinephrine	O	O Barbiturates
O	O Codeine	O	O 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
Notice of Privacy Practices for Protected Health Information

<u>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.</u>

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.

<u>Your Health Information Rights</u>
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 <u>not</u> 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 Drs. Chang, Berger, Dentico-Olin, or Thayer. 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

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. Furthermore, you agree to the method for which this treatment is being billed and that you agree to pay your share.

______________________________	______________________________	________________
Signature of Responsible Party	Printed Name	Date