KENNETH L. FONG, D.D.S.
ONE DANIEL BURNHAM COURT SUITE 390-C
SAN FRANCISCO, CA 94109 415-775-8055

SHARING RESPONSIBILITY FOR HEALTH

DATE:

Patient's Name	Birthdate	Age	Sex

Home Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Email

Social Security #	Driver's License	Marital Status	Name of Spouse

Employer	Occupation	How Long

Employer's Address	City	State	Zip

IN CASE OF EMERGENCY

Name	Relationship

Address	City	State	Zip

Home Phone	Cell Phone	Work Phone

DENTAL INSURANCE - If you have dental insurance, please complete the following:

Name of Insured	Name of Insurance Company	Insurance Co. Contact #

Employer	Insured Social Security # /I.D. #	Group Policy #

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Name	Relationship

PATIENT ACKNOWLEDGEMENTS

We are a fee-for-service practice, payment is due at each appointment. For those who have dental insurance, we will verify your eligibility and estimate your insurance payment. Your dental health coverage is a contract between you and your insurance company and while we will help file your claim, you are ultimately responsible for your account.

RESPONSIBILITIES

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

DENTAL BENEFIT PLANS

Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice IS NOT a contracted provider with PPO dental benefit plans. We are only contracted with DELTA DENTAL PREMIER.

- If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

- If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CHOOSE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. ☐Y / ☐N Is your general health good?
   If NO, explain: _____
2. ☐Y / ☐N Has there been a change in your health within the last year?
   If YES, explain: _____
3. ☐Y / ☐N Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. ☐Y / ☐N Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. ☐Y / ☐N Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. ☐Y / ☐N Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

☐ Y/ ☐ N Chest pain (angina)	☐ Y/ ☐ N Blood in stools	☐ Y/ ☐ N Frequent vomiting
☐ Y/ ☐ N Fainting spells	☐ Y/ ☐ N Diarrhea or constipation	☐ Y/ ☐ N Jaundice
☐ Y/ ☐ N Recent significant weight loss	☐ Y/ ☐ N Frequent urination	☐ Y/ ☐ N Dry mouth
☐ Y/ ☐ N Fever	☐ Y/ ☐ N Difficulty urinating	☐ Y/ ☐ N Excessive thirst
☐ Y/ ☐ N Night sweats	☐ Y/ ☐ N Ringing in ears	☐ Y/ ☐ N Difficulty swallowing
☐ Y/ ☐ N Persistent cough	☐ Y/ ☐ N Headaches	☐ Y/ ☐ N Swollen ankles
☐ Y/ ☐ N Coughing up blood	☐ Y/ ☐ N Dizziness	☐ Y/ ☐ N Joint pain or stiffness
☐ Y/ ☐ N Bleeding problems	☐ Y/ ☐ N Blurred vision	☐ Y/ ☐ N Shortness of breath
☐ Y/ ☐ N Blood in urine	☐ Y/ ☐ N Bruise easily	☐ Y/ ☐ N Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

☐ Y/ ☐ N Heart disease	☐ Y/ ☐ N AIDS/HIV	☐ Y/ ☐ N Psychiatric care
☐ Y/ ☐ N Family history of heart disease	☐ Y / ☐ N Surgeries	☐ Y/ ☐ N Osteoporosis
☐ Y/ ☐ N Heart attack	☐ Y/ ☐ N Hospitalization	☐ Y/ ☐ N Thyroid disease
☐ Y/ ☐ N Artificial joint	☐ Y/ ☐ N Diabetes	☐ Y/ ☐ N Asthma
☐ Y/ ☐ N Stomach problems or ulcers	☐ Y/ ☐ N Family history of diabetes	☐ Y/ ☐ N Hepatitis
☐ Y/ ☐ N Heart defects	☐ Y/ ☐ N Tumors or cancer	☐ Y/ ☐ N Sexual transmitted disease
☐ Y/ ☐ N Heart murmurs	☐ Y/ ☐ N Chemotherapy	☐ Y/ ☐ N Herpes
☐ Y/ ☐ N Rheumatic fever	☐ Y/ ☐ N Radiation	☐ Y/ ☐ N Canker or cold sores
☐ Y/ ☐ N Skin disease	☐ Y/ ☐ N Arthritis, rheumatism	☐ Y/ ☐ N Anemia
☐ Y/ ☐ N Hardening of arteries	☐ Y/ ☐ N Emphysema or lung disease	☐ Y/ ☐ N Liver disease
☐ Y/ ☐ N High blood pressure	☐ Y/ ☐ N Kidney or bladder disease	☐ Y/ ☐ N Eye disease
☐ Y/ ☐ N Seizures	☐ Y/ ☐ N Stroke	☐ Y/ ☐ N Transplants
☐ Y/ ☐ N Cosmetic surgery	☐ Y/ ☐ N Eating disorders	☐ Y/ ☐ N Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please choose Yes or No for each)

☐ Y/ ☐ N Aspirin	☐ Y/ ☐ N Valium or other sedatives	☐ Y/ ☐ N Codeine or other narcotics
☐ Y/ ☐ N Penicillin or other antibiotics	☐ Y/ ☐ N Latex	☐ Y/ ☐ N Food
☐ Y/ ☐ N Nitrous oxide	☐ Y/ ☐ N Local anesthetic	☐ Y/ ☐ N Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please choose Yes or No for each)

☐ Y/ ☐ N Recreational drugs	☐ Y/ ☐ N Tobacco in any form	☐ Y/ ☐ N Antibiotics
☐ Y/ ☐ N Over-the-counter medicines	☐ Y/ ☐ N Alcohol	☐ Y/ ☐ N Supplements
☐ Y/ ☐ N Weight loss medications	☐ Y/ ☐ N Bisphosphonate (Fosamax)	☐ Y/ ☐ N Aspirin
☐ Y/ ☐ N Anti-Depressants	☐ Y/ ☐ N Herbal Supplements	

Please list all prescription medications: _____

VI. WOMEN ONLY (Please choose Yes or No for each)

☐ Y/ ☐ N Are you or could you be pregnant? If YES, what month? _____

☐ Y/ ☐ N Are you nursing?

☐ Y/ ☐ N Are you taking birth control pills?

VII. ALL PATIENTS (Please choose Yes or No for each)

☐ Y/ ☐ N Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: _____

_____

☐ Y/ ☐ N Have you ever been pre-medicated for dental treatment? If YES, why: _____

☐ Y/ ☐ N Have you ever taken Fen-Phen? If YES, when: _____

☐ Y/ ☐ N Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name : _____ Relationship : _____ Phone Number : _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

VIII. DENTAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Date of Last Dental Visit? _____ Date of Last Dental X-rays? _____

Reason for the Visit? _____

Former Dentist: _____ Phone: _____

Address: _____ Email: _____

If you left your previous dentist, what was the reason? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

IX. AT- HOME ORAL HYGIENE CARE

How often do you brush your teeth? _____ How often do you floss? _____

☐ Y/ ☐ N Do you use any other dental home care products? If YES, which kind: _____

X. PATIENT ORAL EVALUATION

☐ Y/ ☐ N Experiencing pain or discomfort?

☐ Y/ ☐ N Do your gums bleed?

☐ Y/ ☐ N Are your teeth loose?

☐ Y/ ☐ N Do you wear dentures/partials?

☐ Y/ ☐ N Sensitive to hot,cold, sweets, pressure?

☐ Y/ ☐ N Clicking, popping/discomfort in the jaw?

☐ Y/ ☐ N Do you grind your teeth?

☐ Y/ ☐ N Do you wear occlusal guard?

☐ Y/ ☐ N Ever had orthodontic treatment (braces) before?

☐ Y/ ☐ N Does food/floss catch between teeth?

☐ Y/ ☐ N Any upsetting dental experience associated with dental treatment?

☐ Y/ ☐ N Fearful of dentistry or have anxiety with dental treatment?

☐ Y/ ☐ N Ever had a reaction to anesthetic?

☐ Y/ ☐ N Are you happy with your smile?

☐ Y/ ☐ N Do you have dry mouth?

☐ Y/ ☐ N Do you like the shape of your teeth?

Which of the following improvements would you make?

☐ Y/ ☐ N Lighten teeth

☐ Y/ ☐ N Lighten single tooth

☐ Y/ ☐ N Close spaces between teeth

☐ Y/ ☐ N Rebuild fracture (s)

☐ Y/ ☐ N Lengthen

☐ Y/ ☐ N Eliminate crowding

☐ Y/ ☐ N Straighten

☐ Y/ ☐ N Shorten

☐ Y/ ☐ N Repair uneven edges

☐ Y/ ☐ N Eliminate dark or stained fillings

☐ Y/ ☐ N Reduce gums showing

On a scale of 1-10 (with 10 being best), how do you feel about your teeth? _____

Please add anything you feel is important: _____

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) Date

_____ _____

Signature of Dentist Date

SCHEDULING

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a missed appointment fee or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a late arrival fee or deposit to reserve the appointment time again, may be required.

PATIENT AUTHORIZATIONS

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. ☐ YES ☐ NO _____ (initial)

PATIENT COMMUNICATION

Voice Messages: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. _____ (initial)

Email: (edit with regard to the practice's use of secure electronic communication) Except for appointment reminders, we use secure methods to electronically communicate with our patients. Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

I prefer to receive information via the practice's secure communication methods. My email address is _____ .

I consent and accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time. My email address is _____ .

I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time. My email address is _____ .

I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Cellphone: I consent to the dental practice using my cellphone number to (choose one or both) to call or to text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cellphone number is (include area code) _____ _____ (initial)

PAYMENTS AND FINANCIAL ARRANGEMENTS

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: CASH, CHECK, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS. * Please note: We DO NOT accept third-party financing, but we offer our own financing options tailored to fit most budgets.

Returned checks and balances older than 15 days may be subject to additional collection fees and interest charges of 1.5% per month.

RECEIPT OF DENTAL MATERIALS FACT SHEET

Senate Bill 134, signed by the governor in October, requires that beginning January 1, 2002, each dentist is to provide a copy of the DMFS to any patient prior to commencing any dental restorative work. This requirement applies to new patients and patients of record. The dentist is required to obtain a signed acknowledgement that the patient had received the fact sheet, and a copy of the acknowledgement must be placed in the patient's record.

The dentist need only provide DMFS one time to each patient. If the DMFS is updated, the dentist then is required to provide the updated DMFS to all paitents prior to commencing any dental restorative work and to obtain again a signed acknowledgement of receipt.

This new requirement was prompted by a belief that the earlier version had not been routinely discussed with patients, and therefore the requirement was added to SB 134.

NOTE: The Dental Materials Fact Sheet can be found on our website www.kennethfongdds.com under the new patient forms tab. Or you can request a copy on your first visit.

I _____, acknowledge I received from Kenneth L. Fong, D.D.S. a copy of the Dental Materials Fact Sheet dated October 2001.

Patient Signature: _____ Date: _____