DATE:

PATIENT REGISTRATION

ID: _____ Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist: _____

Employer ID: Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Emergy contact #: _____

Referred By:: _____

Kaiser Medical Rec #: _____

Name of Univ./School: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____ .00

Janice Liao, D.M.D. and George Shiao, D.M.D.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

CONSENT FOR SERVICES & OFFICE POLICIES

Financial and Insurance Policies:
It is our objective to provide our patients with cutting edge dental technology, superior dental materials and expert care in a modern comfortable environment.
In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of their visit. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.
Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.
A billing charge of $2.50 per statement period, and a service charge of 1.5% (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. Any accounts past due over 90 days will be forwarded to a collection agency.
The fee estimate listed for dental care can only be extended for a period of sixty days from the date of patient examination.

Policies for X-rays and Dental Records:
X-rays in conjunction with a clinical exam are necessary in order to devise a complete and accurate diagnosis and dental treatment plan. Examination x-rays are generally taken once a year for adults and every six months for children. However, the frequency at which x-rays are taken will be determined based upon each patient's individual dental needs. If you deny recommended xrays, you may be asked to sign an xray declination form.

Office Cancellation Policy:
We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee.

HIPAA:
The Health Insurance Portability and Accountability Act (HIPAA) took effect on April 14, 2003. This federal law requires our office to provide a notice of privacy practices. This policy is posted in the reception area entitled "Notice of Privacy Practices." You may also request a paper copy. We would appreciate you taking the time to sign the bottom of this form certifying you have received this office's Notice of Privacy Practices.

Proposition 65:
The state of California, under proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTAL MATERIALS FACT SHEET". It is required that all patients sign they have received a copy of this document. We would appreciate you taking the time to sign the bottom of this form certifying you have received a copy of the DENTAL MATERIALS FACT SHEET. If you have any questions regarding information contained within the document please feel free to bring your questions to our attention.

I hereby authorize the office of Dr. Janice Liao, D.M.D., and Dr. George Shiao, D.M.D. to perform any necessary diagnostic examinations, and x-ray procedures they deem necessary, including photographs, and the administration of anesthetic or treatment as deemed necessary or advisable in the treatment of my dental condition.
I also have read the above conditions of payment and agree to their content.

_____
Signature of patient, parent or guardian

Signature for receipt of DENTAL MATERIALS FACT SHEET:

_____

Signature for acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES:
you may refuse to sign this acknowledgement

_____