***Lily H. Siu, D.M.D., P.C.***
380 West Portal Avenue, Suite A • San Francisco, CA 94127
Tel: (415) 566-3833 • Fax: (415) 566-2909
www.drlilysiu.com email: drlilysiu.info@gmail.com

THIS INFORMATION IS NECESSARY FOR OUR FILES AND THE MAINTENANCE OF YOUR HEALTH WHILE UNDER TREATMENT.
IT WILL BE CONSIDERED CONFIDENTIAL.

## Patient Information

Patient Name: _____ Today's Date: _____
Last, First MI

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Address: _____
Street City State Zip Code

Phone: Home: _____ Work: _____ Cell: _____ Email: _____

Social Security #: _____ Date of Birth: _____

If patient is minor, parent or legal guardian name: _____
Last, First MI

Who may we thank you for referring you to our practice? _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____
Street City State Zip Code

## Insurance Information

| | Primary Insurance | | Secondary Insurance |
|---|---|---|---|
| Subscriber Name | | Subscriber Name | |
| Subscriber SSN/ID# | | Subscriber SSN/ID# | |
| Date of Birth | | Date of Birth | |
| Relationship to Subscriber | ■ Self ■ Spouse ■ Child ■ Other | Relationship to Subscriber | ■ Self ■ Spouse ■ Child ■ Other |
| Employer Name | | Employer Name | |
| Employer Phone # | | Employer Phone # | |
| Insurance Company | | Insurance Company | |
| Insurance Group # | | Insurance Group # | |
| Insurance Phone # | | Insurance Phone # | |

## Medical History

**Have you ever had any of the following? Please check those that apply:**

| | | | | | |
|---|---|---|---|---|---|
| ■ AIDS or HIV infection | ☐ Allergies _____ | ☐ Anemia | ☐ Arthritis | ☐ Artificial Joints | ☐ Asthma |
| ☒ Blood Disease | ☐ Bone Medication | ☐ Cancer | ☐ Diabetes | ☐ Dizziness | ☐ Epilepsy |
| ■ Excessive Bleeding | ☐ Fainting | ☐ Glaucoma | ☐ Growths | ☐ Hay Fever | ☐ Head Injuries |
| ■ Heart Disease | ☐ Heart Murmur | ☐ Hepatitis | ☐ High Cholesterol | ☐ High Blood Pressure | |
| ■ Jaundice | ☐ Kidney Disease | ☐ Liver Disease | ☐ Mental Disorders | ☐ Psychiatric Treatment | |

| | | | | |
|---|---|---|---|---|
| ☐ Pacemaker | ☐ Pregnancy | ☐ Radiation Treatment | ☐ Respiratory Problems | ☐ Rheumatic Fever |
| ☐ Sinus Problems | ☐ Stroke | ☐ Thyroid Disease | ☐ Tuberculosis (TB) | ☐ Ulcers |
| ☐ Venereal Disease | ☐ Smoking/Tobacco use | ☐ Prosthetic Device | ☐ Latex Allergy | ☐ Penicillin Allergy |
| ☐ Drug Addiction | ☐ Chemotherapy | ☐ Recently weight loss | ☐ Birth Control | ☐ Blood Transfusion |

· Are you under a Physician's care? ☐ Yes ☐ No Date of last complete physical exam: _____

· Name of current physician: _____ Phone: _____

· Are you taking any medication/drug/herbs? ☐ Yes ☐ No If yes, please describe _____

· Are you taking or have taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, e.g. ZOMETA, AREDIA? (Circle all apply) ☐ Yes ☐ No If yes, please describe _____

· Do you require antibiotic pre-medication before dental treatment? ☐ Yes ☐ No If yes, please explain: _____

· Have you ever been hospitalized? ☐ Yes ☐ No If yes, when _____ and why _____

## Dental History

· Name of current or former Dentist: _____ Date of last dental visit: _____

· Address: _____ Phone: _____

· How often do you brush your teeth? _____ Floss? _____ Reason for today's visit: _____

· Have you ever had complications or prolonged bleeding following dental treatment? ☐ Yes ☐ No

· Do you feel pain in any of your teeth? ☐ Yes ☐ No Do you clench or grind your teeth? ☐ Yes ☐ No

· Are any of your teeth loose, tipped, shifted or chipped? ☐ Yes ☐ No Does food catch between your teeth? ☐ Yes ☐ No

· Are any of your teeth sensitive to heat, cold, or pressure? (Circle all that apply) ☐ Yes ☐ No

· Do you have any pain or soreness in the muscles of your face? ☐ Yes ☐ No Does your jaw click or pop? ☐ Yes ☐ No

· Have you had any unpleasant dental experience? ☐ Yes ☐ No _____

· Do you have any questions or concerns? ☐ Yes ☐ No _____

**To the best of my knowledge, the foregoing questions have been accurately answered. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.**

**X** _____ **Date** _____

Signature of patient, parent or legal guardian

## Authorization and Consent

**General Consent to Treatment**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that recommended treatments will be discussed with me prior to being started. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

**Release of Information**

I authorize release of any information concerning my (or my child's) health care, advice and treatment to third party payors and/or other health professionals.

**Assignment of Insurance Benefits**

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

**X** _____ **Date** _____

Signature of patient, parent or legal guardian

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# FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We are committed to providing you the best possible dental care. We realize that every person's financial situation is different and for this reason, we have worked hard to provide a variety of payment options to help you receive the dental care that you need and deserve. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important life enhancing care.

## Payment Options

***For our Non-Insured Patients:***

- We are happy to offer a 5% Senior Citizen courtesy for treatments paid in full by cash or check.
- We also offer NO INTEREST Payment Plans from CareCredit.
- Payments may also be made using Visa, Master Card or Debit Card.
- For larger, more comprehensive treatment plans, a 50% deposit is required prior to your initial treatment appointment.

***For our Insured Patients:***

- Your dental insurance is a contract between you and your employer, and the insurance company. We are not a party to that contract. We will be happy to submit dental claims to your insurance company, however, we can make no guarantee of coverage or payment. Since the policy is an agreement between you and your insurance company, all patients are responsible for all charges, co-payments, non-covered services or any difference between fees charged and insurance payments for services rendered. We will do everything possible to work with your insurance company to help you receive the full benefits.
- Estimated co-payment amounts are due on the day of treatment and are not subject to the courtesy.
- Please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

## Missed Appointments/No Shows

- Appointment times are reserved especially for you. Any patient that misses or cancels without giving 48 hours notice two times in a calendar year will be subject to a fee of $75.00.

## Billing

- Please note any outstanding balances older than 60 days may be subject to additional collection fees and finance Charges at the rate of 1.5% monthly (18% annually).
- Please note that returned checks will be subject to a processing charge of $50.00.

**We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.**

**I have read the policies described in this form. I agree to abide by the terms outlined. I understand and accept my financial responsibilities.**

_____ _____

**Patient, Parent or Guardian Signature** **Date**

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380 West Portal Ave, Suite A, San Francisco, CA. 94127

# PHOTOGRAPH CONSENT

I, _____ GIVE MY CONSENT TO Lily H. Siu D.M.D. take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile and intraoral features, pre-, during, and post treatment of (patient name) for the purposes of internal office use in dental records or for use in treatment planning, education, publication in professional journals and/or advertising. I understand that my identity will be blurred in most cases and that my personal information will be protected.

I hereby waive any right that I may have to inspect or approve the finished product(s) and advertising copy to which the photographs may be applied.

I hereby release, discharge, and agree to save harmless Dr. Lily Siu, and all persons acting under her permission of authority or those for whom (he/she) is acting, from any liability by virtue of any blurring, distortion, alternation, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publication thereof, including without any limitation any claims for libel or invasion of privacy.

I have a right to restrict the use of photographic images as indicated here: _____.

I hereby warrant that I am of legal age and have the right to contract my own name, or I am not of legal age and my parent/legal guardian whose signature is witnessed below is executing this release. I/my guardian have read the above consent prior to its execution, and I/my is fully familiar with the agreement.

Patient Name Print: _____ Date: _____

Signature: _____

Guardian (if under legal age) Print Name: _____

Guardian Signature: _____

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San Francisco, CA. 94127

## Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (Print full name), have received a copy of the Notice of Privacy Practices from Lily H. Siu, D.M.D.

**Patient Signature:** _____ **Date:** _____

If this acknowledgement is signed by a personal representative/guardian on behalf of the patient, complete the following:

**Personal Representative/Guardian's name:** _____

**Relationship to Patient:** _____

**Signature:** _____ **Date:** _____

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**For Office Use only**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify)_____