PAUL HALL, D.D.S., INC.
DIPLOMATE, AMERICAN BOARD OF
ORAL AND MAXILLOFACIAL SURGERY
ALDRICH A. SY, D.D.S., M.D., INC.
DIPLOMATE, AMERICAN BOARD OF
ORAL AND MAXILLOFACIAL SURGERY
BRIAN K. HUI, D.D.S., M.D.
ORAL AND MAXILLOFACIAL SURGERY

PHYSICIAN'S MEDICAL CENTER
901 CAMPUS DRIVE, SUITE 303
DALY CITY, CA 94015

PHONE 650.992.7874
FAX 650.992.5902

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Ini. _____

Address_____ City, State, Zip _____

Date of Birth_____ SSN_____ Sex: Male or Female

Home#_____ Work#_____ Cell# _____

Email Address: _____

If Student: Name of School_____ Student Status: Part time or Full Time

Dentist's Name/Referred by_____ Tel# _____

Physician's Name_____ Tel# _____

If patient is other than Insurance Subscriber:

Patient Resides with:_____ Relationship: _____

[ ] I Do NOT Have Dental Insurance

Primary Dental Insurance

Name of Dental Insurance_____ Ins ID/SSN# _____

Insured's Name_____ Group # _____

Insured's DOB_____ Relationship_____

Insured's Employer_____ Tel# _____

Secondary Dental Insurance

Name of Dental Insurance_____ Ins ID/SSN# _____

Insured's Name_____ Group # _____

Insured's DOB_____ Relationship_____

Insured's Employer_____ Tel# _____

Medical Insurance Information

Name of Medical Ins_____ Medical Ins Phone# _____

Subscriber Name/ DOB_____ Ins ID/SSN# _____

Person Responsible for Account

Name_____ Phone #_____ Relationship _____

Emergency Contact

Name_____ Relationship_____

Home#_____ Work#_____ Cell# _____

Pharmacy Information

Pharmacy Name_____ Address _____

By Law, children under 18 years of age must be accompanied by a parent/legal guardian to appointments with Dr. Paul Hall, Dr. Aldrich Sy & Dr. Brian Hui.

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MEDICAL HISTORY

1) Are you in Good Health? ☐ YES ☐ NO

2) Are you pregnant? ☐ YES ☐ NO
If Yes _____Months

3) Have you been hospitalized within the last 5 years?
☐ YES ☐ NO

4) Are you a smoker? ☐ YES ☐ NO

5) Are you currently under the care of a Physician?
☐ YES ☐ NO

6) Have you taken Fen-Phen? ☐ YES ☐ NO

7) Do you have a TMJ disorder? ☐ YES ☐ NO

8) List all medications taken within the last 5 years:

_____

_____

9) Do you have any drug allergies? Including Latex. Please list below:

_____

_____

10) Have you or any member of your family ever had difficulty with anesthesia? ☐ YES ☐ NO

11) Please answer Yes/No if you have had any of the following:

Adrenal insufficiency	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Hyperthyroid	☐ YES ☐ NO
Artificial hip prosthesis	☐ YES ☐ NO	Immunal deficiency	☐ YES ☐ NO
Bleeding problems	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO
Blood transfusions	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Bronchitis	☐ YES ☐ NO	Psychological Disorder	☐ YES ☐ NO
Congestive heart failure	☐ YES ☐ NO	Radiation Therapy	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO	Sinus problems	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO	Stomach ulcers	☐ YES ☐ NO
Heart attack	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Heart Defect	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO

12) If you are having intravenous anesthesia today have you eaten/drank anything in the last 12 hours ☐ YES ☐ NO
13) Have you had complications/ a bad experience with a Dentist in the past? ☐ YES ☐ NO

Signature_____ Date _____

Witness_____ Date _____

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OFFICE POLICY

Our Office Policy is to provide the best treatment with efficiency. However, due to unforeseen circumstances and/or emergencies, it is difficult to see our scheduled patients on time. If the Doctor is behind schedule, we will inform you and reschedule your appointment without penalty if you wish. If you are an emergency patient, we are happy to see you at the earliest time of the day, but please understand that you may have to wait to be seen.

I understand that Dr. Aldrich Sy/Dr. Brian Hui/Dr. Paul Hall begins treatment with a consultation. The Doctor will needan x-ray, imagery, and/or other aids in order to recommend me the necessary procedures and services involved in the treatment. I acknowledge that it is the Doctor's standard of care for me to have a consultation first before scheduling the surgery. I understand and acknowledge that the office cannot inform me if I am eligible for the initial visit as frequency limitations may apply to these services and my dental insurance does not guarantee payment.

I understand that I am fully responsible for the payment of all costs associated with the procedure(s) and service(s) performed by the doctor and the team. I understand that my dental insurance company does not guarantee payment and any portion not covered by the insurance will be my responsibility. I acknowledge that any insurance coverage that I have will be based on a contract between my doctor, the insurance company, and me, the policyholder, and/or my employer. Since the insurance may not cover 100%, I am required to make a copayment of 20% or more depending on my benefits and the amount I have available. Should my insurance company pay the full amount, I will be reimbursed, via check, for the co-payment I paid at the office. I understand that I am also responsible for all fees even if I have dual coverage after both insurances have paid or denied payment due to "Non-Duplication Policy." Therefore, I understand and acknowledge that I am liable for all fees not paid or declined by the insurance company (even after initially approving the services). As a courtesy to the patient, the doctor's team will bill my insurance company on the date of service. If for any reasons the insurance denies payment, I will be responsible for the remaining balance, which will be billed to me after 30 days from the service date.

If I have no insurance or the doctor is NOT in-network with my insurance company, I am required to make the payments in full on the day of the service unless I have made prior arrangements with the Doctor.

I hereby authorize insurance payment directly to the treating Doctor. If I wish to have the insurance payment assigned to me, I will pay the full amount of treatment to the Doctor on the day of surgery. I understand that I am financially responsible for all charges not covered by my insurance company.

All returned checks are subject to a $50 returned check fee. If an appointment is not cancelled/rescheduled 2 business days prior to the scheduled date, a $100 charge will apply. Any balance remaining unpaid for 30 days from the last payment date will accrue a 1.5% interest charge. The office will work with me by arranging a reasonable agreement, should I have financial difficulty. Any unsettled account balance not payable within 90 days will be assigned to a collection agency. I understand that I will be liable for a 50% collection-processing fee. (This is a practice that we DO NOT wish to observe).

I consent to be contacted by the Doctor, a representative of the office, or a collection agency (or agent) for any unpaid balance by mail at any address that I provided the office or by facsimile, phone number (cell phone or landline), or email.

By California Law, all minors MUST be accompanied by a parent/legal guardian for ALL appointments.

Patient's Name _____

_____

Patient's or legal guardian's signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have read/received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

_____
Relationship to Patient (if other than SELF)

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
- ! Communications barriers prohibited obtaining the acknowledgement
- ! An emergency situation prevented us from obtaining acknowledgement
- ! Other (Please Specify)

_____

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.

(You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge $75 plus $30 for every hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances n which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form. Please inform our staff if you want any digital forms in paper format and we will provide them for you.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: DR. ALDRICH SY, DR. BRIAN HUI & DR. PAUL HALL

Telephone: 650-992-7874 Fax: 650-992-5902 E-mail: info@sfbayos.com

Address: 901 CAMPUS DRIVE #303, DALY CITY, CA 94015