



# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes No DK</b>				<b>Yes No DK</b>							
Do you wear contact lenses? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED								
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____								
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____								
<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.			<b>Yes No DK</b>				<b>Yes No DK</b>							
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>														
			<b>Yes No DK</b>				<b>Yes No DK</b>				<b>Yes No DK</b>			
Artificial (prosthetic) heart valve .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Previous infective endocarditis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged valves in transplanted heart .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital heart disease (CHD)						Asthma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Unrepaired, cyanotic CHD .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired (completely) in last 6 months .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired CHD with residual defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
						Tuberculosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<b>Yes No DK</b>				<b>Yes No DK</b>				<b>Yes No DK</b>			
Cardiovascular disease. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Angina .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Arteriosclerosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congestive heart failure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged heart valves .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart attack .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart murmur .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Low blood pressure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High blood pressure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other congenital heart defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis, jaundice or liver disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting spells or seizures .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, specify: _____						Sleep disorder .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mental health disorders .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Specify: _____						Type of infection: _____								
Kidney problems .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Severe headaches/ migraines .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually transmitted disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Name of physician or dentist making recommendation:						Phone:								
Do you have any disease, condition, or problem not listed above that you think I should know about? .....												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain:														

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**  
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 health 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. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**ADVANCED DENTISTRY**  
GENERAL COSMETIC RESTORATIVE

BRIAN W. FONG, D.M.D.  
3023 Broadway Street Redwood City, CA 94062  
Phone: 650.474.0551 Fax: 650.474.0553 www.drbrfanfong.com

## **DENTAL INSURANCE INFORMATION SHEET**

*To better assist you with the processing of your dental claims please provide us with the following information.*

**PRIMARY POLICY HOLDER'S NAME:**

\_\_\_\_\_

**POLICY HOLDER'S SS# OR INSURANCE  
ID#:** \_\_\_\_\_

**POLICY HOLDER'S DOB:**

\_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

**INSURANCE COMPANY:**

\_\_\_\_\_

**INS. CO. PHONE #:** \_\_\_\_\_

**GROUP#:** \_\_\_\_\_

### **\*\*\*IF YOU HAVE DUAL INSURANCE FILL THIS SECTION OUT\*\*\***

**SECONDARY POLICY HOLDER'S NAME:**

\_\_\_\_\_

**POLICY HOLDER'S SS# OR INSURANCE  
ID#:** \_\_\_\_\_

**POLICY HOLDER'S DOB:**

\_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

**INSURANCE COMPANY:**

\_\_\_\_\_

**INS. CO. PHONE #:** \_\_\_\_\_

**GROUP#:** \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT:**  
**NOTICE OF PRIVACY PRACTICE**

\*You May Refuse to Sign This Acknowledgement

I, \_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian  
Signature: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

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We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but for the following reason we could not:

- Individual refused to sign
- Communication barriers prohibit obtaining Acknowledgement
- An emergency situation prevented obtainment

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**DENTAL MATERIAL FACT**  
**SHEET**

I acknowledge that I have received and or read the on-line copy of the Dental Board of California “The Facts about Fillings” pamphlet.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian  
Signature: \_\_\_\_\_

# Office and Payment Policy

Welcome to Advanced Dentistry, the office of Dr. Brian Fong. We offer you an over-friendly staff and superior services; we consider our time with you priceless. **However, we request 48-hour advance notice of cancellations or rescheduling of any type. Without this courtesy, a fee of \$100.00 per hour scheduled will be applied to your account. This fee will can be waived one time upon receipt of our OOPS Letter.**

Our fees reflect our professional commitment to excellence. Co-payments are expected at the time of service, unless other financial arrangements are made in advance. The following reflect our payment policies:

- **Payment in full is expected on the date services are rendered by cash, check or credit card (Visa, MasterCard, Discover, or Amex). For patients with insurance, co-payment and deductible is expected from you at the time services are rendered.**
- For patients with no insurance, please make financial arrangements (CareCredit) with the Office Manager before or by the scheduled date of service.

## **Important reminders for patients with dental insurance:**

- Your dental benefit program is a contract between you, your employer and the insurance company. We are not involved in this equation.
- Our fees generally but not necessarily fall within the usual and customary fee structure. This fee is determined by your insurance carrier.
- **Not all dental services are covered benefits. COMPOSITES (white fillings) may be reduced to the amalgam fees. Some major restorative procedures: Onlays and Porcelain Crowns may be reduced to a lower fee leaving a higher patient co payment. BLEACHING or other cosmetic procedures are usually not be covered.**
- **You (not your insurance company) are responsible to us for all fees for services rendered to you.**
- At patient request, an Authorization / Pre Treatment Estimate can be submitted to your insurance prior to scheduling procedures. This may take up to 8 weeks for your insurance to reply.

***ALL ACCOUNTS THAT REMAIN UNPAID FOR 90 DAYS WILL BE BILLED FOR IMMEDIATE COLLECTION***

**We appreciate this opportunity to serve you**

I HAVE READ AND I UNDERSTAND THE ABOVE OFFICE AND PAYMENT POLICY

X \_\_\_\_\_

DATE: \_\_\_\_\_