

Patient Information

Name: _____ Sex: M F ___ Married ___ Single
Last First MI Preferred Name
Date of Birth: _____ Social Security Number: _____

Address:

Street Apt # City State Zip

Home Phone () _____ Cell Phone () _____

We send confirmations by Email and Text; do you have text messaging on your cell phone? _____
PLEASE NOTE: IF YOU DO NOT WANT TO RECEIVE TEXT MESSAGE REMINDERS OR YOU ARE CHARGED BY YOUR MOBILE PROVIDER PLEASE INFORM THE FRONT OFFICE.

Email Address _____

Employer (School if Student) _____ Work Phone () _____

How did you hear about our office? _____

Next of Kin/Emergency Contact: _____
Name, Relationship and Telephone #

Person Financially Responsible/Insured Party

Name: _____ Patient's Relationship: Self Spouse Child Other
Last First MI

Date of Birth: _____ Social Security Number: _____

Employer: _____ Work phone: () _____ Hours: _____

Employer's Address: _____

Insurance Co: _____ Effective date: _____ Phone: () _____

Insurance Co. Address: _____

Secondary Insurance Information

Name: _____ Patient's Relationship: Self Spouse Child Other
Last First MI

Date of Birth: _____ Social Security Number: _____

Employer: _____ Work phone: () _____ Hours: _____

Employer's Address: _____

Insurance Co: _____ Effective date: _____ Phone: () _____

Assignment of Benefits and Release of Information

I authorize Dr Benjamin J. Chew DDS to release to the above insurance companies any information, including diagnosis and dental records, necessary to process my dental claims. I also authorize payment to go directly to Dr Benjamin J. Chew DDS for the dental benefits that are otherwise payable to me.

Signature of Responsible Party _____ Date _____

HEALTH HISTORY

PATIENT NAME _____ SSN _____ Date of Birth _____

Patient Address _____

Phone Home: _____ Work: _____ Cellular: _____

1. Name and address of your medical doctor _____

2. Are you under medical care now? Yes No For What? _____

3. Are you taking any medications? Yes No Please list _____

4. Are you taking recreational drugs, tobacco in any form or alcohol? Yes No _____

5. Do you have allergies to food, medication or drugs? Yes No _____

6 Name of your last dentist and date of your last dental care _____

7 When was your last series of full mouth X-rays? _____

8. Have you had problems with prior dental treatment? Yes No _____

HAVE YOU EXPERIENCED: (PLEASE CIRCLE APPROPRIATE ANSWER)

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|--------------------------|
| 9. | Yes | No | Chest pain (angina)? | 20. | Yes | No | Dizziness? |
| 10. | Yes | No | Swollen ankles? | 21. | Yes | No | ringing in the ears? |
| 11. | Yes | No | Shortness of breath? | 22. | Yes | No | Headaches? |
| 12. | Yes | No | Recent weight loss, fever, night sweats? | 23. | Yes | No | Fainting spells? |
| 13. | Yes | No | Persistent cough, coughing up blood? | 24. | Yes | No | Blurred vision? |
| 14. | Yes | No | Bleeding problems, bruising easily? | 25. | Yes | No | Seizures? |
| 15. | Yes | No | Sinus problems? | 26. | Yes | No | Excessive thirst? |
| 16. | Yes | No | Difficulty swallowing? | 27. | Yes | No | Frequent urination? |
| 17. | Yes | No | Diarrhea, constipation, blood in stools? | 28. | Yes | No | Dry mouth? |
| 18. | Yes | No | Frequent vomiting or nausea? | 29. | Yes | No | Jaundice? |
| 19. | Yes | No | Difficulty urinating or blood in urine? | 30. | Yes | No | Joint pain or stiffness? |

DO YOU HAVE OR HAVE YOU HAD: (PLEASE CIRCLE APPROPRIATE ANSWER)

- | | | | | | | | |
|-----|-----|----|---|-----|-----|----|------------------------------------|
| 31. | Yes | No | Heart disease? | 47. | Yes | No | VD (Syphilis or gonorrhea) |
| 32. | Yes | No | Heart attack or heart defects? | 48. | Yes | No | Herpes? |
| 33. | Yes | No | Heart murmurs? | 49. | Yes | No | Kidney or bladder disease? |
| 34. | Yes | No | Rheumatic fever? | 50. | Yes | No | Thyroid or adrenal disease? |
| 35. | Yes | No | Stroke or hardening of arteries? | 51. | Yes | No | Diabetes? |
| 36. | Yes | No | High blood pressure? | 52. | Yes | No | Psychiatric care? |
| 37. | Yes | No | Stomach problems or ulcers? | 53. | Yes | No | Radiation treatment? |
| 38. | Yes | No | TB, emphysema, lung disease or asthma | 54. | Yes | No | Chemotherapy? |
| 39. | Yes | No | Hepatitis or other liver disease? | 55. | Yes | No | Prosthetic heart valve? |
| 40. | Yes | No | History of diabetes, heart murmurs, tumors? | 56. | Yes | No | Artificial joint? |
| 41. | Yes | No | AIDS or ARC? | 57. | Yes | No | Hospitalization or surgery? |
| 42. | Yes | No | Tumors or cancer? | 58. | Yes | No | Blood transfusion? |
| 43. | Yes | No | Arthritis or rheumatism? | 59. | Yes | No | Pacemaker? |
| 44. | Yes | No | Eye disease? | 60. | Yes | No | Contact lenses? |
| 45. | Yes | No | Skin disease? | 61. | Yes | No | Latex Allergy? |
| 46. | Yes | No | Anemia? | 62. | Yes | No | Prescribed Fen-Phen (Diet Pills) ? |

WOMEN ONLY:

63. Yes No Are you or could you be pregnant/nursing 64. Yes No Taking birth control pills?

ALL PATIENTS:

65. Yes No Do you have, or have you had, any other diseases or medical problems not listed on 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.

Patient's Signature _____ Date _____

RECALL REVIEW _____ Date _____

RECALL REVIEW _____ Date _____

RECALL REVIEW _____ Date _____

Policies for the Office of Dr. Benjamin Chew

Thank you for selecting our office to serve your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. We require that you read and sign this policy.

INSURANCE PAYEMENTS: We are happy to process any insurance claim as a service to you at no charge. Please keep in mind that any insurance payment estimate that we provide for you is only an estimate, we cannot predict what the insurance company will do. We may accept assignment of benefits for verified insurance, but **all co-payments and deductibles are due at the time of treatment.** *You are fully responsible for all fees in their entirety.* We are proud that our fees reflect the time that Dr. Chew spends with each patient as well as the overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules, and may be above insurance allowances. We have noticed that in recent years, insurance benefit plans have lowered their benefits, no longer pay for necessary treatment, decreased their table of allowances, added waiting period on most procedures, increased deductibles, and yet have kept the yearly maximums the same as 20 years ago. You may wish to complain to your company benefits representative should your benefits be less than you expected.

We will be happy to pre-authorize necessary treatment to give you an estimate of the cost but this is not a guarantee of payment. **If your insurance company requires pre-authorization, it is your responsibility to inform us.**

MINOR PATIENTS: The parent (or guardian) accompanying a minor is responsible for full payment, regardless of divorce decree. A parent or legal guardian must accompany minors under 16. Unaccompanied minors over 16 may be treated provided a parent or legal guardian has approved the treatment and payment has been arranged. Patients over 18 are considered adults and are responsible for full payment.

MISSED / CANCELLED APPOINTMENTS: We are requiring a minimum of two-business day's notice for any scheduling changes. **If a scheduling change is made without proper notification, a \$50.00-\$100.00 fee (depending on the type of appointment) will be applied to your account.** In the event that there are multiple appointments that are changed without proper notice, a refundable reservation fee of \$50.00 -\$100.00 (depending on the type of appointment) will be required to schedule any future appointments in our office. If an appointment change is made on a reserved appointment without proper notification, the reservation fee will **NOT** be refunded.

We realize that on occasion emergencies arise making it difficult to give proper notification. Your effort to inform us as soon as possible will be greatly appreciated, as we have patients in need that could use the reserved time given enough notification.

METHODS OF PAYMENT: WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND ATM CARDS. We also offer interest free financing for three, six or twelve months.

If you have any questions or concerns please let us know. I understand and agree to this financial policy.

Signature of Patient or Responsible Party _____
SSN _____ Driver's License # _____

Benjamin J. Chew, DDS, FAGD
2147 Mowry Ave. Suite B2
Fremont, CA 94538
510-745-9299

Dr. Benjamin Chew is involved in dental education with the University of Pacific, Arthur A. Dugoni School of Dentistry and the California Academy of Dentistry's Master track program. As both an educator and continual student of dentistry, he predominately uses photographs for educational purposes. This photograph authorization allows Dr. Benjamin Chew to acquire photos for use both in education and in patient dental treatment.

Photograph Authorization

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, and bridges, or dentures and these images will become part of my dental record.

I hereby give my consent for Dr. Benjamin Chew to take photographs, slides, and /or videotape of _____ face, jaw, and teeth. I also grant permission to reproduce, print and /or publish these images for use in articles or lectures. Photographs, slides, and/or videotape will not be used in advertisements without prior consent.

I understand that the information disclosed under this authorization may be subject to re-disclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date.

Patient or Legal Guardian's Signature

Date

DR. BENJAMIN J. CHEW D.D.S.

2147 Mowry Ave #B2

Fremont, CA 94538

(510) 745-9299

Section One

I _____, acknowledge that I have received the following form(s) from Dr. Benjamin Chew's office.

Please initial by each form that you have received.

- 1. _____ Dental Material Fact Sheet (Will be given to you at your appointment)
- 2. _____ Practice Scheduling Guidelines
- 3. _____ Financing Options
- 4. _____ Authorization For Release of Photographs
- 5. _____ Notice of Privacy Practices. (Please fill out section 2)

Patient's signature	Patient's Name (if minor)	Date
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Section Two

Do we have permission to:	Yes	No
1. Leave a message on your answering machine at home?	_____	_____
2. Leave a message at your place of employment?	_____	_____
3. Discuss your medical or dental condition with any member of your household?	_____	_____

If yes, whom: _____

Signature

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)

Benjamin J. Chew D.D.S
2147 Mowry Avenue, Suite B-2 Fremont, CA 94538
510.745.9299

OUR FINANCING OPTIONS

Thank you for selecting our office to serve your dental needs. We believe it is important not only to provide the highest quality dental care, but also to make this type of care affordable for our patients. We have made arrangements for our patients, which allow payment to be convenient and flexible. Please review the plans listed below. Give some thought to which one may serve you best in meeting your needs. We will consult with you on specific details to make your obligation comfortable for you.

For Treatment under \$300.00 we offer:

Cash, Check, Debit Card, CareCredit, Chase Health Advance, or Credit Card for full treatment.

Cash, Check, Debit Card, CareCredit or Credit Card for patient's estimated portion. (With verification of insurance benefits.) * Please note insurance information below.

(a) For Treatment or Co-Payments between \$300.00 and \$1000:

1. Estimated payment at each visit with cash, check or credit card. (With most insurance plans following benefit verification.) * Please note insurance information below.
2. Pay 50% at the beginning of your treatment and the balance before the completion of your treatment.

(b) For Treatment or Co-Payments over \$1000

1. Estimated payment at each visit with cash, check or credit card. (With most insurance plans following benefit verification.) * Please note insurance information below.
2. Pay 50% at the beginning of your treatment and the balance before the completion of your treatment.
3. Three, Six or Twelve month interest free financing.
4. Low monthly payments for up to Sixty months

(i) * Note to patients with insurance

We are happy to process any insurance claim as a service to you at no charge. Please keep in mind that any insurance payment estimate that we provide for you is only an estimate, we can not predict what the insurance company will do. *You are fully responsible for all fees in their entirety.* We are proud that our fees reflect the time that Dr. Chew spends with each patient as well as the overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules, and may be above insurance allowances. We have noticed that in recent years, insurance benefit plans have lowered their benefits, no longer pay for necessary treatment, decreased their table of allowances, added waiting period on most procedures, increased deductibles, and yet have kept the yearly maximums the same as 20 years ago. You may wish to complain to your company benefits representative should your benefits be less than you expected.

We will hold your account open for 60 days after treatment is completed to allow your insurance company to pay us. At the end of 60 days you will be responsible to pay the balance of your account in full.

If your account is assigned to an attorney for collection and / or suit, the prevailing party shall be entitled to reasonable attorney's fees in addition to all other costs.

All returned checks will incur a \$25.00 fee.

Benjamin J. Chew D.D.S
Section 1.02 2147 Mowry Avenue, Suite B-2 Fremont, CA 94538
510.745.9299

Practice Scheduling Guidelines

In an effort to reduce the number of sudden, unforeseen changes in our schedule, we are now implementing new scheduling guidelines. We are requiring a minimum of two-business day's notice for any scheduling changes. **If a scheduling change is made without proper notification, a \$50.00-\$100.00 fee (depending on the type of appointment) will be applied to your account.** In the event that they are multiple appointments that are changed without proper notice a refundable reservation fee of \$50.00 -\$100.00 (depending on the type of appointment) will be required to schedule any future appointments in our office. If an appointment change is made on a reserved appointment without proper notification, the reservation fee will **NOT** be refunded.

We realize that on occasion emergencies arise making it difficult to give proper notification. Your effort to inform us as soon as possible will be greatly appreciated, as we have patients in need that could use the reserved time given enough notification.

We thank you in advance for your cooperation!

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 by 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 (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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 you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or 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 authorized 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 you \$0.50 for each page, \$50.00 per hour for 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 in 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.

Restriction: 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 to 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 the 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 a 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: Benjamin J. Chew, D.D.S.

Telephone: (510) 745-9299

Address: 2147 Mowry Ave Ste. B-2 Fremont, CA 94538