SF BAY
ORAL SURGERY
& DENTAL IMPLANTS

ALDRICH SY, DDS, MD
Diplomate, American Board of Oral & Maxillofacial Surgery

BRIAN HUI, DDS, MD
Diplomate, American Board of Oral & Maxillofacial Surgery

PHYSICIAN'S MEDICAL CENTER
901 Campus Dr. Ste. 303, Daly City, CA 94015
Tel (650) 992 7874 Fax (650) 992 5902
info@sfbayos.com www.sfbayos.com

Patient Information

Last Name _____ First Name _____ Middle Ini. _____

Address _____ City, State, Zip _____

Date of Birth _____ SSN _____ Sex: Male or Female or Other

Home# _____ Work# _____ Cell# _____

Email Address: _____

Dentist's Name/Referred by _____ Tel# _____

Physician's Name _____ Tel# _____

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

If patient is a minor:

Patient Resides with: _____ Relationship: _____

If Student: Name of School _____ Student Status: Part time or Full Time

Primary Dental Insurance [ ] I Do NOT Have Dental Insurance

Name of Dental Insurance _____ ID# _____

Subscriber's Name _____ Subscriber's DOB _____

Insured's Employer _____ Group# _____

Relationship to Patient _____ Subscriber's Address (If different from patient's address) _____

Secondary Dental Insurance [ ] I Do NOT Have Any Other Dental Insurance

Name of Dental Insurance _____ ID# _____

Subscriber's Name _____ Subscriber's DOB _____

Insured's Employer _____ Group# _____

Relationship to Patient _____ Subscriber's Address (If different from patient's address) _____

Medical Insurance [ ] I Do NOT Have Medical Insurance

Name of Medical Ins _____ Medical Ins Phone# _____

Subscriber Name/ DOB _____ Ins ID/SSN# _____

Person Responsible for Account [ ] Self [ ] If Other, Pls Indicate Below:

Name _____ Phone # _____ Relationship _____

Emergency Contact

Name _____ Relationship _____

Home# _____ Work# _____ Cell# _____

Pharmacy Information

Pharmacy Name _____ Address _____

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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

Patient's Name _____

_____

Patient's or legal guardian's signature Date

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OFFICE POLICY

Our office is committed to providing the highest quality treatment with efficiency and care. However, due to unforeseen circumstances or emergencies, there may be occasional delays in seeing patients as scheduled. If the doctor is running behind, we will notify you and offer to reschedule your appointment without penalty, should you choose to do so. Emergency patients are seen at the earliest available time, but please understand there may be a wait.

I understand that Dr. Aldrich Sy and Dr. Brian Hui begins all treatment with a consultation. This may include x-rays, imaging, or other diagnostic tools to help the doctor recommend the appropriate treatment and procedures. I acknowledge that this consultation is a required part of the standard of care and must be completed before any surgical procedure is scheduled. I also understand that the office may not be able to confirm my eligibility for the consultation in advance, as insurance frequency limitations may apply, and dental insurance does not guarantee payment.

I understand that I am fully responsible for the cost of all procedures and services provided by the doctor and the clinical team. While the office will bill my dental insurance as a courtesy, I recognize that insurance coverage is not guaranteed. Any amount not covered by my insurance, including deductibles and co-payments, will be my responsibility. I acknowledge that insurance coverage is based on the contract between myself (the policyholder), my employer (if applicable), the insurance company, and in some cases, the provider.
Because insurance may not cover the full cost of treatment, I am required to make a co-payment of 20% or more, depending on my specific benefits and coverage availability. If my insurance ends up covering the full amount, I will be reimbursed by check for any co-payment I made at the time of service. I am also responsible for all fees not covered by my insurance, including those denied under a "Non-Duplication of Benefits" policy. I understand that I am financially liable for all services provided, regardless of insurance decisions, even if initial approvals are later revoked.

If I do not have dental insurance, or if the doctor is not an in-network provider for my plan, I agree to pay for all services in full on the day they are rendered, unless I have made prior financial arrangements with the office.

I authorize payment of insurance benefits directly to the treating doctor. If I wish for insurance payments to be made to me instead, I agree to pay the full treatment amount at the time of service. Regardless of insurance coverage, I remain financially responsible for all charges not paid by my insurance.

Appointment Policy

- Appointments may be canceled or rescheduled without penalty by providing at least 3 business days' notice.
- For Saturday appointments and procedures scheduled for 1.5 hours or longer, 5 business days' notice is required.
- Late cancellations, late rescheduling, or missed appointments are subject to a fee of $100 or 10% of the estimated copay deposit collected at the time of scheduling, whichever is greater.

Financial Policy & Fees

- A $50 fee will be charged for any returned checks.
- Balances remaining unpaid 30 days after the date of service will incur a $25 monthly late fee.
- Accounts unpaid for over 90 days may be referred to a collection agency and will be subject to a 50% processing fee. (Please note: This step is a last resort and not our preferred course of action.)

We are happy to work with you to establish a reasonable payment arrangement in case of financial difficulty.

By signing this policy, I consent to be contacted by the doctor, office staff, or a designated collection agency regarding any unpaid balances. Contact may be made by mail, phone (cell or landline), email, or fax using the contact information I have provided.

Minors Policy:

As required by California law, all minors must be accompanied by a parent or 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 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 you $0. __ for each page, $__ 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.

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 Web Site or b 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 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
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