☐ **William C. Cliff, DDS, MSD** ☐ **G. Robert Hsu, DDS, MS**
☐ **Daniel L. Rose, MS, DDS** ☐ **June C. Chang, DDS**

LAST NAME:	
FIRST NAME: MIDDLE INITIAL:	
HOME STREET ADDRESS:	
CITY: STATE: ZIP:	
HOME #: ( )	☐ MALE ☐ FEMALE
WORK #: ( )	SOC. SEC.: - -
CELL #: ( )	DATE OF BIRTH:

Dental Insurance:	EMPLOYER:
Subscriber Name:	Kaiser Medical Insurance ☐ YES ☐ NO
Subscriber Number:	If yes, Kaiser Medical No.:
REFERRING DENTIST:	
TELEPHONE NUMBER: ( ) CITY:	
MEDICAL PHYSICIAN:	
TELEPHONE NUMBER: ( ) CITY:	
EMERGENCY CONTACT: Telephone No. ( )	

METHOD OF PAYMENT ****FEES MUST BE PAID AT THE COMPLETION OF TREATMENT****

☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

As a professional courtesy we will gladly bill your insurance company. Please be advised your co-payment is an **ESTIMATE** based on information provided by your insurance company prior to the time of service. If, **FOR ANY REASON**, your insurance company does not pay your claim, full payment for all services provided is your responsibility. **Please be advised that endodontic treatments are often subject to frequency limitations, meaning only one endodontic treatment, per tooth, per a specific period of time. It is your responsibility to know the frequency limitations of your insurance policy. If you have any questions regarding this matter, please ask a schedule coordinator for more information.**

I certify that I have read and I understand the statement above.

_____ _____

Patient's (Guardian) Signature Date

IMPORTANT – After the completion of your endodontic treatment you will need final restoration. Please contact your general dentist **promptly** for an appointment for the permanent filling and/or crown. The temporary filling you will receive will last **no longer than four to six weeks**. Delay in obtaining final restoration may result in decay, fracture, recontamination or extraction. Any additional treatment as a result of delay in receiving final restoration would be at an additional cost to you and possibly not covered by your insurance.
I certify that I have read and understand the statement above.

_____ _____

Patient's (Guardian) Signature Date

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is our responsibility to update this medical history annually or when any changes occur.

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes _____ ☐ No_____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures? (Answer to the right)

	Y	N		Y	N		Y	N		Y	N
Rheumatic fever			Hay fever/Sinus problems			Jaundice/Liver Disease			Cancer		
Mitral valve prolapse			Asthma			Hepatitis			Kidney disease		
Heart murmur			Respiratory Problems			HIV / AIDS			Are you on dialysis		
High blood pressure			Tuberculosis			Infectious mononucleosis			Arthritis / joint disease		
Low blood pressure			Emphysema			Gallbladder disease			Stomach ulcers		
Chest pain/ Angina			Do you smoke			Fainting spells			Contagious diseases		
Heart attack(s)			Do you use chewing tobacco			Convulsions / epilepsy			Abnormal bleeding		
Damaged heart valves			History of drug abuse			Stroke			Anemia		
Chronic fatigue			History of alcohol abuse			Thyroid disease			Tumor or growth		
Mental Health problems			Immune system problems			Blood disorders			Radiation / chemotherapy		
Bronchitis/ Chronic cough			Diabetes			Blood transfusions			Sexually transmitted diseases		

MEDICATIONS YOU ARE CURRENTLY TAKING (Answer to the right)

	Y	N		Y	N
ARE YOU REQUIRED TO PRE-MEDICATE PRIOR TO TREATMENT			Pain Medication		
Have you ever taken diet pills			Muscle Relaxers		
Blood Thinners (Coumadin, Aspirin, Advil)			Diabetes Medication		
Bisphosphonates/ Diphosphonates **(calcium replacement)**			Antidepressants		
Please list any other medication you are taking:			Blood Pressure Medication		
Additional Medications:					

ARE YOU ALLERGIC TO OR HAD A REACTION TO: (Answer to the right)

	Y	N		Y	N
Penicillin or other antibiotics **(please list)**			Local Anesthetic		
Valium or other tranquilizers			Codeine or other narcotics		
Sulfa Drugs			Advil / Motrin		
Aspirin			**Latex**		

LIST ANY OTHER MEDICATIONS OR ANTIBIOTIC YOU ARE ALLERGIC TO:

PLEASE LIST ANY ALLERGIES OTHER THAN DRUG ALLERGIES:

1. – 4. BELOW FOR WOMEN ONLY: (women note; antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1. Is there a possibility of pregnancy? Yes No
2. Trimester? One Two Three
3. Are you nursing? Yes No
4. Are you taking birth control pills? Yes No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my endodontics, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient_____Date: _____ Doctor signature:_____Date:_____

39572 Stevenson Pl. Ste. 121, Fremont, CA 94539
2817 Crow Canyon Rd. Ste. 100 San Ramon, CA 94583
20700 Lake Chabot Rd. Ste. 201 Castro Valley, CA 94546

Mission Hills Endodontics, a Dental Practice

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

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

X _____ _____
Patient or Representative Signature Date

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 _____Communication barriers
____Emergency situation _____ Other

Consent for use and Disclosure of Health Information

To the patient--Please read the following carefully:

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices while treating you, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we attain. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting (925) 829-5711 or 8265 Village Parkway, Suite E, Dublin, California 94568.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we receive your revocation, and that we may decline to treat you or decline to continue treating you if you revoke this consent.

I, _____ have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____
Patient or Representative's Signature Date

As a professional courtesy we will gladly bill your insurance company. Please be advised your co-pay is an estimate based on information provided by your insurance company prior to the time of service. If, for any reason, your insurance company does not pay your claim, full payment for all services provided is your resonsibility.

_____(initial here)