

**PATIENT INFORMATION**

Name Last	First	M.I.	SS#	Sex M / F	DOB / /	Age
Street Address			City	State	Zip Code	
Whom may we thank for referring you to our practice?						
If the patient is a minor, please give parent's/guardian's name.						

**RESPONSIBLE PARTY INFORMATION**

Name Last	First	M.I.	SS#	DOB	Relationship To Patient	
Street Address (if different from above)			City	State	Zip Code	
How long at this address?	Previous Address (if less than 3 years)					
Home Phone	Work Phone	Mobile Phone	Email			
Employer			Occupation	# Years Employed		
Business Address			City	State	Zip Code	
Spouse's Last	First	M.I.	SS #	DOB	Relationship To Patient	
Employer			Occupation	# Years Employed		
Business Address			City	State	Zip Code	
Home Phone (if different)	Work Phone	Mobile Phone	Email			
Street Address (if different)			City	State	Zip Code	

**INSURANCE INFORMATION**

Insured Name Last	First	SS #
Insurance Co.	Group #	Local #
Insurance Co. Address	State	Zip Code
If you have dual insurance coverage, please give additional information		
Insured Name Last	First	SS #
Insurance Co.	Group #	Local #
Insurance Co. Address	State	Zip Code

**EMERGENCY INFORMATION**

Name Of Nearest Relative Not Living With You			
Home Address	City	State	Zip Code
Work Address	City	State	Zip Code
Home Phone	Work Phone		

I understand that when appropriate, my credit reports may be obtained to extend credit.

Signed (Parent/Guardian if minor) \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



# Health History

Today's Date \_\_\_\_\_  
 Child's Name Last \_\_\_\_\_ First \_\_\_\_\_ Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Referred by \_\_\_\_\_  
 Child's Physician \_\_\_\_\_ Physician's Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Last Medical Visit \_\_\_\_\_  
 Physician's Address \_\_\_\_\_  
 Reason for This Dental Visit \_\_\_\_\_

Yes No

1. Does your child have a health problem?  Yes  No
2. Is your child being treated for any medical problem now?  
If yes, for what?  Yes  No
3. Is your child taking any medicine now?  
If so, what?  Yes  No
4. Has your child ever been a patient in a hospital?  
If yes, why?  Yes  No
5. Has your child ever received general anesthesia or surgery?  Yes  No
6. Has your child ever had a blood transfusion?  Yes  No
7. Is your child allergic to anything (medicine, food, latex, metal e.t.c.)? Please list: \_\_\_\_\_  Yes  No

### Reviewer Comments



8. Has your child ever been diagnosed to have any of the following conditions or problems?

- | Yes                   | No                    |                              | Yes                   | No                    |                             | Yes                   | No                    |                        |
|-----------------------|-----------------------|------------------------------|-----------------------|-----------------------|-----------------------------|-----------------------|-----------------------|------------------------|
| <input type="radio"/> | <input type="radio"/> | Abnormal Bleeding/Hemophilia | <input type="radio"/> | <input type="radio"/> | Drug/Alcohol Abuse          | <input type="radio"/> | <input type="radio"/> | Mental Disability      |
| <input type="radio"/> | <input type="radio"/> | ADHD/Learning Impairment     | <input type="radio"/> | <input type="radio"/> | Drug Reaction               | <input type="radio"/> | <input type="radio"/> | Mumps                  |
| <input type="radio"/> | <input type="radio"/> | AIDS/HIV                     | <input type="radio"/> | <input type="radio"/> | Endocrine                   | <input type="radio"/> | <input type="radio"/> | Muscle                 |
| <input type="radio"/> | <input type="radio"/> | Anemia                       | <input type="radio"/> | <input type="radio"/> | Epilepsy                    | <input type="radio"/> | <input type="radio"/> | Mouth Breathing        |
| <input type="radio"/> | <input type="radio"/> | Autoimmune                   | <input type="radio"/> | <input type="radio"/> | Emotional/Psychiatric       | <input type="radio"/> | <input type="radio"/> | Nerve                  |
| <input type="radio"/> | <input type="radio"/> | Arthritis/Joint Disease      | <input type="radio"/> | <input type="radio"/> | Eye/Vision                  | <input type="radio"/> | <input type="radio"/> | Nose/Sinus             |
| <input type="radio"/> | <input type="radio"/> | Asthma                       | <input type="radio"/> | <input type="radio"/> | Fainting                    | <input type="radio"/> | <input type="radio"/> | Nutritional Deficiency |
| <input type="radio"/> | <input type="radio"/> | Autism                       | <input type="radio"/> | <input type="radio"/> | Gastrointestinal            | <input type="radio"/> | <input type="radio"/> | Polio                  |
| <input type="radio"/> | <input type="radio"/> | Blood Pressure               | <input type="radio"/> | <input type="radio"/> | Headaches                   | <input type="radio"/> | <input type="radio"/> | Pregnancy              |
| <input type="radio"/> | <input type="radio"/> | Bone/Orthopedic              | <input type="radio"/> | <input type="radio"/> | Hearing                     | <input type="radio"/> | <input type="radio"/> | Rheumatic Fever        |
| <input type="radio"/> | <input type="radio"/> | Brain Injury/Stroke          | <input type="radio"/> | <input type="radio"/> | Heart Disease               | <input type="radio"/> | <input type="radio"/> | Scarlet Fever          |
| <input type="radio"/> | <input type="radio"/> | Bronchitis/Sore Throat       | <input type="radio"/> | <input type="radio"/> | Heart Murmur                | <input type="radio"/> | <input type="radio"/> | Skin                   |
| <input type="radio"/> | <input type="radio"/> | Cancer/Tumor                 | <input type="radio"/> | <input type="radio"/> | Hepatitis, Type _____       | <input type="radio"/> | <input type="radio"/> | Sickle Cell Anemia     |
| <input type="radio"/> | <input type="radio"/> | Cerebral Palsy               | <input type="radio"/> | <input type="radio"/> | Jaw Joint                   | <input type="radio"/> | <input type="radio"/> | Sleep Apnea/Snoring    |
| <input type="radio"/> | <input type="radio"/> | Chemotherapy/Radiation       | <input type="radio"/> | <input type="radio"/> | Jaundice                    | <input type="radio"/> | <input type="radio"/> | Smoking/Tobacco Use    |
| <input type="radio"/> | <input type="radio"/> | Chicken Pox                  | <input type="radio"/> | <input type="radio"/> | Kidney                      | <input type="radio"/> | <input type="radio"/> | Specific Syndromes     |
| <input type="radio"/> | <input type="radio"/> | Cleft Lip/Palate             | <input type="radio"/> | <input type="radio"/> | Leukemia/Lymphoma           | <input type="radio"/> | <input type="radio"/> | Spina Bifida           |
| <input type="radio"/> | <input type="radio"/> | Convulsion/Epilepsy/Seizures | <input type="radio"/> | <input type="radio"/> | Liver                       | <input type="radio"/> | <input type="radio"/> | Tetany                 |
| <input type="radio"/> | <input type="radio"/> | Diabetes                     | <input type="radio"/> | <input type="radio"/> | Lung/Pneumonia/Tuberculosis | <input type="radio"/> | <input type="radio"/> | Tonsils/Adenoids       |
| <input type="radio"/> | <input type="radio"/> | Diphtheria/Whooping Cough    | <input type="radio"/> | <input type="radio"/> | Gastrointestinal            | <input type="radio"/> | <input type="radio"/> | Veneral Disease/STD    |

9. Is there anything else we should know about your child?  
\_\_\_\_\_

I certify that I have read and understood all questions. I will not hold OPDSF, doctors, or any staff member for any errors or omissions we may have made in completing this form.

\_\_\_\_\_  
Signature of a Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Purpose of Consent:** By signing this form, you 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 discloses we may make of your protected health information, and of other important matters about your protected health information. A copy of our notices 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, we will issue a revised Notice of Privacy Practices, which will contain all changes. This may apply to any of your protected health information that we maintain.

**Right to Revoke:** You have the right to revoke this consent at any time by providing a written notice of your revocation. Please note that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decide to treat you or discontinue to treat you if you revoke this consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I further acknowledge I have received a copy of your Notice of Privacy Practices.

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

*If this consent is signed by a personal representative on behalf of the patient, please complete the following:*

Representative's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, \_\_\_\_\_, acknowledge that I have reviewed the Dental Materials Fact Sheet of the California Dental Association.

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

*If this consent is signed by a personal representative on behalf of the patient, please complete the following:*

Representative's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### FOR PRACTICE USE ONLY

We attempted to obtain written acknowledgement and consent of our Notice of Privacy Practices and Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): \_\_\_\_\_



Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

## GENERAL PRACTICE INFORMATION & FINANCIAL POLICY

Thank you for choosing **Orthodontics Pediatric Dentistry San Francisco** as your child(ren)'s dental home. We promise to provide you with excellent care and treat you with compassion and integrity. As we work together, kindly note the following general practice information and financial policy:

**Hours of Operation:** Our business hours are Monday through Friday from 8:00AM to 5:00PM and two Saturdays a month from 8:00AM to 4:00PM. We are closed for major holidays. We offer after hour emergency care. Please call our office to be directed to the doctor on-call.

**New Patient Appointment:** At each New Patient Visit, your child will receive a comprehensive examination, a dental cleaning and a topical fluoride treatment. Sometimes when the child is very young, the cleaning or fluoride treatment may not be indicated.

**Radiographs (x-rays):** Selected dental x-ray is recommended on an individually basis depending on the risk assessment for dental decay and gum disease as well as history of dental injuries.

**Routine Dental Checkups:** Check-up visits are generally scheduled 6 months ahead; some are every 3-4 months depending on your child's needs. At each check-up, your child will receive an examination, cleaning, fluoride treatment, and radiographs as needed.

**Dental Treatment:** If your child requires any treatment, it will be discussed with you. Upon your consent you will need to sign the treatment plan before treatment is rendered. There may be additional consent forms depending on the type of dental procedure.

**Minor Consent:** If a parent/legal guardian is unable to accompany the child to an appointment, we ask that you sign the Minor Consent Form ahead of time. This form can be obtained from our front office or on our website, [www.opdsf.com](http://www.opdsf.com).

**Cancellation/Failed Appointment Fees:** Each appointment visit is specially reserved for you and your child. We send appointment reminders via email, text and by phone. We ask that you give us a 48-hour notice if you need to cancel or reschedule. We reserve the right to charge \$60 for any late cancellation or failed appointment.

**Patient Co-payments/Deductibles:** As parent/legal guardian/guarantor, you are responsible for the cost of any treatment not covered by your dental benefits. The estimated copayment is due at the time of service. Sometimes insurance companies pay on a lower fee schedule. We will bill or refund you the difference after your insurance makes the final payment. We ask payment be submitted within 30 days unless a financial agreement has been made with our practice.

**Accurate Insurance Information:** To help file your insurance claims we ask that you provide us with accurate and updated dental benefits information so that your claims can be processed in a timely manner.

**Out-of-Network Plans:** For some out-of-network PPO plans that pay subscribers directly, we will require full payment from you at the time of service.

**Past Due Accounts / Returned Check Fees:** There is 3% monthly interest rate on any balance past 30 days, and a \$30 fee for any returned check. Financial arrangement may be made on an individual basis.

By signing this document, I agree to comply with OPDSF's general practice information and financial policy. I understand I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I am also authorizing the payment of dental and medical benefits to Dr. Dorothy Pang, and for her practice to release all information necessary to secure all payment. The assignment of benefits will remain effective until I revoke it in writing. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. A photocopy of this assignment is considered to be as valid as an original.

Name of parent/legal guardian/responsible party: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

## NOTICE OF PRIVACY PRACTICES

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect \_\_\_\_\_ and will remain in effect until we replace it.

\_\_\_\_\_ (Initial)

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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

### Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations. For example:

#### Treatment

We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

#### Payment

We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

#### Health Care Operations

We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

#### Unsecured Email

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

#### 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 your 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 health care. 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.

# Notice of Privacy Practices (continued)

## Marketing Health-Related Services

We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

## Change of Ownership

If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

## Required by Law

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

## Public Health

We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

## 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

## Appointment Reminders

We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

## Sign-In Sheet and Announcement:

Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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Signature of Patient/Parent/Legal Guardian

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Name of Patient/Parent/Legal Guardian

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Relationship to patient (Self/Parent/Legal Guardian)





Peter C.F. Lee, D.D.S., M.S. & Dorothy T.Y. Pang, D.D.S., M.S.

## INFORMED CONSENT FOR GENERAL PEDIATRIC DENTAL PROCEDURES

Thank you for choosing us as your child (ren)'s dental home. We promise to provide you with excellent care and treat you with compassion and integrity. As we work together, kindly review and acknowledge our informed consent for general pediatric dental procedures. Some procedures may require a separate consent form, which will be provided before treatment begins.

I hereby authorize and direct **Orthodontics Pediatric Dentistry San Francisco** (Dr. Dorothy Pang and associates) to perform the following dental procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-ray), diagnostic aids and photography for documentation purpose for my child:

- Application of dental sealants
- Treatment of decayed teeth with fillings, crowns and root canal therapy
- Treatment of diseased or injured oral tissues, hard or soft
- Removal of badly decayed or injured teeth
- Removal of one or more teeth (primary and/or permanent) for orthodontic treatment
- Replacement of missing teeth with dental prosthesis
- Placement of space maintainer(s) after premature loss of primary teeth
- Placement of a habit appliance for correction of finger/thumb sucking habit
- Treatment of developmental abnormalities

Almost all treatment involving fillings, repair and removal of teeth require the use of **local anesthetics**. Common post-treatment problems from local anesthesia include gum bruising, bleeding, discomfort, canker sores, soft tissue numbness causing accidental lip/tongue/cheek biting and sometime inadvertent abrasion and scratching. Other complications are extremely rare, but state law requires them to be mentioned. These include but not limited to the risk of infection, allergic reactions, scarring, brain injuries, and other complications that may require hospitalization or may even be fatal.

**I understand the recommended treatment. The alternative options, including no treatment, have also been explained to me. I further understand that although good results are expected, the possibility and nature of complications cannot be accurately anticipated. Therefore, there can be no guarantee, expressed or implied, as to the result of the treatment or as to cure.**

**All my questions about the procedures have been answered in a satisfactory manner. The consent will remain in effect until such time I choose to rescind in writing.**

Name of parent/legal guardian/guarantor: \_\_\_\_\_

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

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT MANAGEMENT TECHNIQUES

Every effort will be made to obtain cooperation from your child and to ensure safety and comfort. Below is the list of behavior management techniques that we often use at OPDSF to minimize apprehension and disruption:

**Positive reinforcement**  
**Voice modulation**  
**Nitrous oxide (separate consent)**

**Tell-show-do**  
**Hand-holding**  
**Time-out**

**Distraction**  
**Tooth-pillow**  
**Parent leaving the room**

Sometimes, for the more apprehensive child, minimal to moderate **oral sedation** is indicated. Sedation consent is required.

**Hospital Dentistry** is available to those with extensive treatment and/or with special health care needs. General anesthesia consent is required. Very occasionally, under emergency circumstances, **safety restraint** may be indicated with parent's consent.

\_\_\_\_\_ Patient/parent/legal guardian/guarantor initials