SOUTH PASADENA ORAL AND MAXILLOFACIAL SURGERY
1141 FREMONT AVENUE
SOUTH PASADENA, CA 91030
626.799.2999

OFFICE FINANCIAL POLICY

WELCOME! Thank you for coming to our office. This form is to avoid any misunderstanding regarding method of payment so that we may provide you with the best possible care.

Dr. Stephen Goei and his staff are here to help you in all aspects of your dental care, including financial arrangements. **Our basic policy is that payment is made at the time service is rendered, unless special arrangements are made in advance.**

I understand that dental services furnished to me are charged directly to me[my account] and that I am personally responsible for payment of all dental services. This includes, but is not limited to, all radiographs, as well as all procedures performed to me in this office (Emergency and Non-Emergency).

If I carry **insurance**, I understand that this office will help prepare my insurance forms **as a courtesy** to assist in making collections from insurance companies and will credit such collections to my account. However, this office cannot render services on the assumption that all charges will be paid by an insurance company. This office tries its' best to estimate the amount your insurance company will cover, but we **do not guarantee** your **eligibility** and the **amount** of coverage until actual payment is received. **The amount of the deductible, as well as co-payments, are payable at the time of service.**

I understand that this office will bill me for the remaining portion of my balance, if any, once all insurance claims and payments have been received. If I fail to pay my balance by the 25th of each month, I understand that a interest charge of 1.5%(18% per year) of the remaining balance will be charged to my account, and in turn, I will be responsible for the full amount. If I do not make payments after 3 months of billing, I understand that I will be sent to Collections (Credit Management Services and Transworld Systems Inc.). Furthermore, I agree to pay a $15.00 service charge on all **Returned Checks**.

I certify that I have read the above conditions of treatment and understand and agree to their content. In addition, I certify that I have been given a copy of this financial policy form.

_____ _____

Patient's Signature **Date**

_____

Please print your first and last name

_____ _____

Signature of Financially Responsible Party If Other Than Patient **Date**

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WELCOME! So that we may provide you with the best possible care please complete both sides of this medical history form. All information is completely confidential.

START HERE:
PATIENT INFORMATION

DATE			
PATIENT NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO			
BIRTH DATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF YOU ARE FILLING THIS FORM OUT FOR YOUR CHILD OR RELATIVE, PLEASE FILL OUT THIS PORTION WITH YOUR INFORMATION.

NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTH DATE	AGE	MALE	FEMALE
SOCIAL SECURITY NO.		RELATIONSHI TO PATIENT	

DENTAL INSURANCE

PRIMARY CARRIER	
NAME OF INSURED	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER	
INSURED BIRTH DATE	DATE EMPLOYED
INSURED EMPLOYEE NO.	
INSURED SOCIAL SECURITY NO.	

SECONDARY CARRIER	
NAME OF INSURED	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER	
INSURED BIRTH DATE	DATE EMPLOYED
INSURED EMPLOYEE NO.	
INSURED SOCIAL SECURITY NO.	

ACCOUNT INFORMATION

PATIENT		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE NO.	EXT.	

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE NO.	EXT.	

REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

NAME OF PERSON OR OFFICE		
PHONE NO.		
ADDRESS		
❑ YELLOW PAGES	❑ SCHOOL	❑ WORK
❑ OTHER:		

CONSENT FOR TREATEMENT

1. I authorize Dr. Stephen T.T. Goei or designated staff to take x-rays, study models, photography and any other diagnostic aids deemed appropriate to make a thorough diagnosis of (patient name)_____'s medical or dental needs.
2. Upon such diagnosis, I authorize Dr. Stephen T.T. Goei to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____(initial)

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, or within five (5) days of billing if credit shall be extended unless other financial arrangements have been made. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18% per annum) may be added to my account. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

_____ _____

Signature of parent or responsible party Date

_____

Relationship to Patient

SOUTH PASADENA ORAL AND MAXILLOFACIAL SURGERY

HEALTH HISTORY

Patient's Name_____ Date_____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)?..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes?..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis?..... Y N
   - L. Stomach Ulcers or Colitis?..... Y N
   - M. Glaucoma?..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system?..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers?..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs?..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?..... Y N
   - I. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals, diet drugs(i.e. Pfen-fen):_____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)?..... Y N
   - B. Penicillin or other antibiotics?..... Y N
   - C. Sedatives, Barbiturates?..... Y N
   - D. Aspirin or Ibuprofen?..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list..... Y N

     _____

     _____
10. A. Do you smoke or chew Tobacco?..... Y N
    How much per day? .....
    B. Do you drink Alcohol? ..... Y N
    How much per day? .....
    C. Do you use any recreational drugs? ..... Y N
    What type?_____How often?_____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything?..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant?..... Y N
    - B. Are you nursing?..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

      _____initial

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Medical Update: I have ready my Health History dated _____and confirm that it adequately states past and present conditions.

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

South Pasadena SPOMS Oral & Maxillofacial SURGERY

We are updating our records and need to have your pharmacy information, so all of the prescriptions we write for you will be sent directly to your pharmacy.
If you do not have a pharmacy, please choose one where you would like your prescriptions to be sent to.

PHARMACY INFORMATION

Pharmacy Name _____ Phone _____

Pharmacy Address _____
Street

Pharmacy Address _____
City State Zip Code

PLEASE LIST ANY ALLERGIES TO MEDICATIONS:

_____

PATIENT INFORMATION

Patient Name _____ Gender M F
First Last

Date of Birth _____ / _____ / _____ Phone _____

Address _____
Street

Address _____
City State Zip Code

Name of Parent/Guardian (if minor) _____
First Last

SOUTH PASADENA ORAL AND MAXILLOFACIAL SURGERY
Stephen T. T. Goei, D.D.S., M.S.

Notice of Privacy Practices
For Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL 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 laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out 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. We reserve the right to change our privacy practices and 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. Per your request we may also use or disclose your health information to a pharmacy.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. In order to obtain payment for your dental services we will provide information about you and your dental care to your dental insurance company.

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.

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 institutions or law enforcement officials 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. We will charge you a reasonable cost-based fee for expenses such as copies. Contact us to obtain a full explanation of our fee structure.

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 grant your request, 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. Your request must be submitted in writing and it must specify the alternative means or location.

Amendment: You have the right to request that we amend your health information. (Your request must be submitted in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you would like more information about our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision 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 request that we communicate with you by alternative means or alternative locations, you may submit your complaints or requests to us in writing by using the contact information listed below. You may also 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.

E-mail: myoralsurgeon@spoms.com

Telephone: (626) 799-2999 **Fax:** (626) 799-1739

Address: 1141 Fremont Avenue, South Pasadena, CA 91030

SOUTH PASADENA ORAL AND MAXILLOFACIAL SURGERY
Stephen T. T. Goei, D.D.S., M.S.

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received and reviewed a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Print Name

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

1141 Fremont Avenue ♦ South Pasadena, CA 91030-3226 ♦ 818-799-0506 ♦ 818-799-2999
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