Bernal DENTAL CARE
Yuhao Gao, DDS, Ph.D *3283 Bernal Ave, Ste108, Pleasanton, CA 94566* *(925)249-9242*

PATIENT REGISTRATION

ID:____Chart ID:_____
Office Use Only

Patient Information

First Name:_____ Last Name:_____ Middle Initial:_____

Patient is: Ǐ Responsible Party Ǐ Policy Holder

Address: _____City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: Ǐ Female Ǐ Male Marital Status: Ǐ Married Ǐ Single Ǐ Divorced Ǐ Separated Ǐ Widowed

Birth date:_____ Social Security #: _____ Drivers Lic#:_____

E-mail: _____ Ǐ I would like to receive email correspondences

Employment Status: Ǐ Full Time Ǐ Part Time Ǐ Self Employed Ǐ Retired Ǐ Unemployed

Student Status: Ǐ Full Time Ǐ Part Time

Referred By: _____ Name of person or office referring you to our practice: _____

Responsible Party Information

(if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address: _____Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

Ǐ Responsible Party is Policy Holder for Patient Ǐ Primary Policy Holder Ǐ Secondary Policy Holder

Insurance Information

Primary:

Name of Insured:_____ Relationship to Insured: Ǐ Self Ǐ Spouse Ǐ Child Ǐ Other

Insured Birth date:_____Group #: _____Carrier ID:_____

Employer:_____Address:_____City, State, Zip:_____

Insurance Company:_____Address: _____City, State, Zip:_____

Secondary:

Name of Insured:_____ Relationship to Insured: Ǐ Self Ǐ Spouse Ǐ Child Ǐ Other

Insured Birth date:_____Group #: _____Carrier ID:_____

Employer:_____Address:_____City, State, Zip:_____

Insurance Company:_____Address: _____City, State, Zip:_____

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MEDICAL HISTORY

PATIENT NAME_____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Ĭ Aspirin Ĭ Penicillin Ĭ Codeine Ĭ Acrylic Ĭ Metal Ĭ Latex Ĭ Local Anesthetics

Ĭ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE _____

DOCTOR SIGNATURE_____ **DATE**_____

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Office Policies & Consents

____ HIPAA

Initial

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations by Yuhao Gao, D.D.S. I have the right to read the Notice of Privacy Practices before deciding to sign this consent. This notice provides a description of uses and disclosure taken to my protected health information and of other important matters about my protected health information.

I also have the right to revoke this consent at any time by giving Yuhao Gao D.D.S. written notice of revocation submitted to the office manager or treatment provider. (Notice: revocation of this consent will not affect any action taken in reliance on this consent before receiving the revocation, and that Yuhao Gao, D.D.S. may decline to give any treatment or to continue treatment once this Consent is revoked.)

____ ASSIGNMENT AND RELEASE

Initial

I certify that I, and/or my dependent(s), have insurance coverage indicated on the Patent Registration and assign directly to Dr. Yuhao Gao may also use my healthcare information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is competed for one year from the date of my last treatment.

____ DENTAL MATERIALS FACT SHEET

Initial

I acknowledge that I have read the Dental Material Fact Sheet (The Facts About Fillings) developed by the Dental Board of California. I understand that this sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations. I understand that I should review this information to make a fully informed decision regarding dental restoration treatment. I also understand that I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with the dentists.

____ I ACKNOWLEDGE, UNDERSTAND, AND ACCEPT THE FOLLOWING OFFICE POLICIES:

Initial

(24 Hour Cancellation Policy): Each patient is required to provide advanced notice to allow Yuhao Gao, D.D.S. to arrange office schedules. Failure to notify any cancellation of appointments 24 hours in advance will result in a $40 fee. Three such incidents shall be considered as automatic noncompliance and withdrawal of dental treatment.

(Payments) Co-payments and/or Payments are due when services are rendered. An estimate of your financial responsibilities shall be provided prior to or during your visit. If you did not receive an estimate a copy shall be made immediately upon request.

(Insurance Claims) We are NOT contracted with your insurance company(ies) and therefore have no authority of eligibility, benefits, fee schedules, or other membership entitlements. Thus as a courtesy, Dr. Yuhao Gao will process insurance claims on your behalf but balances after 60 days will be submitted to collections.

(Information Update) Each patient is responsible for updating any changes to health, medication, insurance coverage, and/or personal information including work performed at other offices, contact information, job changes, etc.

Patient/Guardian Signature_____ **Date**_____

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Dear Patient,

All of us concerned about the recently diagnosed of Coronavirus (COVIC-19) in the United States, as well as the rest of the world

Bernal Dental Care, in accordance with the guidelines recommended by the Centers for the Disease Control and Prevention and the American Dental Association, is helping to prevent the spread of the Coronavirus by following the recommended safety precautions, including the collection of the short medical/travel history below.

We appreciate your cooperation in completing these few questions so that together we can do our part to keep you and all of the members of our local community safe and healthy.

Patient Name_____**Date**_____

1) **Has the patient traveled to any non-US country within the previous 30 days? Yes No**
   If Yes, where _____ when did you return? Date_____
2) **Does the patient currently have a fever over 100°F? Yes No**
3) **Is the patient currently experiencing any of the following symptoms: cough (new onset or worsening of chronic cough), short of breath, chills, muscle aches, running nose, sore throat, nausea or vomiting, headache, abdominal pain and/or diarrhea? Yes No**

If you have any questions regarding our efforts to prevent the spread of Coronavirus, please feel free to ask us.

Thank you for your cooperation.

Bernal Dental Care

By my signature below, I agree that the foregoing is true and correct to the best of my knowledge.

_____

Patient Signature (or if Patient is a minor, Parent's Signature)

_____

Patient Full Name