Sol Silverman Oral Medicine Clinic **Patient Information** **University of California, San Francisco**

Name (Last, First, MI): _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Date of Birth: _____ M ☐ F ☐ X ☐ Age: _____

Racial background:

____ Asian ____ African American / Black ____White ____ Pacific Islander

____ American Indian ____ Alaskan Native ____ Other ____ Unknown

Ethnicity: ____Hispanic origin ____ Non-Hispanic origin ____ Unknown

Preferred Language:

___Arabic	___Cantonese	___Chinese	___Danish	___Dutch	___English
___Farsi	___Finnish	___French	___German	___Greek	___Icelandic
___Italian	___Japanese	___Korean	___Mandarin	___Norwegian	___Portuguese
___Russian	___Sign Lang	___Spanish	___Swahili	___Swedish	___Vietnamese

Social Security Number: _____ Email Address: _____

Employer: _____ Occupation: _____

Referring Doctor's Name: _____ Phone: (_____) _____

Fax: (_____) _____ Email Address: _____

Dentist's Name: _____ Phone: (_____) _____

Fax: (_____) _____ Email Address: _____

Physician's Name: _____ Phone: (_____) _____

Fax: (_____) _____ Email Address: _____

Emergency Contact Person: _____ Day-time Phone: (_____) _____

Reason for today's visit _____

Insurance Information

We would be happy to bill your insurance company as a courtesy to you. Please provide our office with a copy of your insurance card and complete the information below to insure accurate processing. If you belong to an HMO group, please provide us with authorization for your visit and/or treatment.

Do you have insurance covering our services? Yes ☐ No ☐

Medical Insurance

Policy Holder's Name: _____ Relationship to patient: _____

Policy Holder's Soc. Sec. #: _____ Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____ Insurance Company Name: _____

Insurance Company Address: _____

_____ Policy #: _____ Group #: _____

Medicare #: _____ Medi-Cal #: _____

Dental Insurance

Policy Holder's Name: _____ Relationship to patient: _____

Policy Holder's Soc. Sec. #: _____ Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____ Insurance Company Name: _____

Insurance Company Address: _____

_____ Policy #: _____ Group #: _____

Medial History

QUESTIONS	YES	NO	COMMENTS
Date of last medical exam, office visits or hospitalization?			
Please list of all medications you take.			
Any change in your health in past 2 years?			
Have you ever taken Fen-phen or Redux?			
Do you smoke, use tobacco, or any recreational drugs?			
Do you drink alcoholic beverages?			
Have you even been given medication prior to dental treatment?			
Do you or have you ever had			
Eye disease (glaucoma, cataracts)?			
Ear, nose or throat problems?			
Heart disease, high blood pressure, heart attack, pacemaker, rheumatic heart disease, valve replacement?			
Respiratory disorders (asthma, emphysema,			

tuberculosis)?			
Gastrointestinal disease (stomach ulcers)?			
Liver disease (hepatitis, cirrhosis, jaundice)?			
Kidney disease?			
Venereal disease (syphilis, gonorrhea, herpes, warts, other)?			
Muscle, bone or joint disorders?			
Skin disease?			
Nervous system disorder (Fainting spells, convulsions, epilepsy) or stroke?			
Psychiatric or emotional problems?			
Endocrine disorders (diabetes, hypothyroidism)?			
Blood disorder of excessive bleeding?			
Immune system disorders (e.g, AIDS)?			
Cancer or cancer treatment (radiation, surgery or chemotherapy)?			
Artificial implants (hip/joint replacement)?			
Are you **allergic** or have you ever been sick from any drugs, medications or dental treatment?			
Other **allergies**: latex, nickel or other metals, pollens, dust, or other substances?			
Are you pregnant or nursing?			
Limitations of activity?			
Is there any additional medical history information you wish to add?			

Signature: (Patient or Guardian)

Date:

CONDITIONS OF TREATMENT UNIVERSITY OF CALIFORNIA, SAN FRANCISCO SOL SILVERMAN ORAL MEDICINE CLINIC

I. FINANCIAL AGREEMENT: The undersigned agrees that in consideration of the services provided, that he/she will pay the regular rates for all charges and professional fees for which he/she is liable. The undersigned agrees that this office is not responsible for negotiating a settlement on a disputed claim and that he/she is responsible for payment of any services not covered by his/her insurance policy. The undersigned understands that, if applicable, he/she may be asked for a co-payment today (cash, check, or credit card payments accepted).

II. TEACHING INSTITUTION: The Department of Stomatology, University of California, San Francisco is a teaching department. Consequently, attending dentist may be assisted by students, interns, residents and postgraduate fellows during the care of each patient. The patient agrees to treatment by these persons while under the direction of the attending doctor.

III. MEDICAL AND SURGICAL CONSENT: The patient's care is under the direction of the attending dentist and consent is given for any medical or surgical treatment, x-ray examination, photography, anesthesia or hospital services rendered the patient under the general and specific instructions of the dentist consistent with the patient's right to informed consent. Records, x-rays, photographs, models, etc. are the property of the Regents of the University of California although you do have conditional access rights to them as stated in the Health & Safety Code of the State of California.

IV. ASSIGNMENTS OF INSURANCE BENEFITS: In the event that the patient is entitled to benefits for hospital or professional services of any type arising out of any insurance policy including Medicare and other government sponsored programs, the patient assigns these benefits to the Regents of the University of California for application to the patient's bill.

V. MEDICARE ASSIGNMENT OF INSURANCE BENEFITS: The undersigned certifies that the information given in applying for payment under Medicare is correct.

VI. PREAUTHORIZATION FOR SERVICE: If the undersigned's insurance coverage requires preauthorization prior to being seen or treated by this clinic, he/she understands it is his/her responsibility to obtain and bring to the Stomatology Clinical Center the appropriate forms authorizing the visit and/or treatment. Failure to do so will leave the undersigned liable for any charges incurred.

VII. RELEASE OF INFORMATION: The department is authorized to furnish any requested information from the patient's record to the referring physician, if any, and to any insurance company, billing intermediary, or government agency including Medicare, for the purpose of obtaining payment of the account for hospital or professional services provided to the patient.

VIII. CLINICAL STUDIES: A participant in a clinical study will not be responsible for study-related charges that the study's consent form says are covered by the study. The participant will be responsible for non-study related charges or for charges incurred if he/she continues to be seen in the Stomatology Clinical Center after the study is completed.

IX. STOMATOLOGY CLINICAL CENTER LABORATORY: Fees for services and procedures must be prepaid. These services are generally not covered by insurance policies and payment is the responsibility of the

undersigned. X. ORAL PATHOLOGY SERVICE: If a biopsy is done in the Stomatology Clinical Center, the patient will receive a separate billing from the Oral Pathology Laboratory for their services.

X. I consent to the use of my x-rays and photographs for professional purposes including professional lecture, research and publications.

XI. Effective Date - November 12, 2015: As part of UC Health, the UCSF Dental Center may electronically exchange some of your registration and health information through a Health Information Exchange between dental clinics at the Medical Center and the Dental Center to streamline the registration process for patients being seen at multiple locations (Medical Center, Mission Bay and Dental Center) and to provide treatment. You may, at the time of registration in the UCSF Dental Center or at any time in the future, request that this data not be shared by opting-out. Registration and health information that has already been shared cannot be revoked. To opt out, complete the standard registration process at the time of registration, or contact us in writing at Patient Services, UCSF Dental Center, 707 Parnassus Ave, Box 0752, San Francisco, CA 94143-0752.

XII. I have read the above and agree to the conditions stated.

Patient Signature:

Signature of legal guardian or authorized representative:

Payment Guarantee/Assignment of Benefits

1. For services rendered by UCSF Sol Silverman Oral Medicine Clinic, I guarantee payment of the account, and agree to pay such account at the time services are rendered, if it will not be paid by insurance carrier or other third party payer (all called “PAYER”)
2. I understand that PAYER may require authorization prior to my receiving treatment, and that it is my responsibility to obtain “prior authorization”. I understand that receiving prior authorization does not guarantee that my PAYER will pay it, because the benefits permitted depend upon my healthcare plan.
3. I further understand that any out-of-pocket charges may be my responsibility.
4. If the amount due the UCSF Sol Silverman Oral Medicine Clinic for services rendered becomes delinquent and the debt is referred to an attorney and/or collection service, I understand and agree that the UCSF Sol Silverman Oral Medicine Clinic may recover from me all costs and expenses incurred in the collection efforts, including any interest due.
5. I acknowledge that if my child/dependent is cared for by the UCSF Sol Silverman Oral Medicine Clinic that I will be responsible for payment for services provided under these same terms and conditions.
6. I agree to pay a late fee if I do not pay in full on the date services are rendered.
7. I understand that I am obligated to pay the full charges of all services rendered to me by the UCSF Sol Silverman Oral Medicine Clinic.

8. I accept full financial responsibility for all items or services which are not covered by the health care service plans. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient, and treatment or tests not authorized by the health care service plan.

9. I agree that I have been given the opportunity to read and receive a copy of the UCSF Sol Silverman Oral Medicine Clinic Notice of Privacy Practices.

10. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I have read the above and agree to the conditions stated.

Patient Signature:

Signature of legal guardian or authorized representative:

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

University of California San Francisco, School of Dentistry

The UCSF Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice are available by accessing our website at http://dentistry.ucsf.edu and may be obtained throughout the UCSF School of Dentistry.

I acknowledge that I have received the Notice of Privacy Practices

Patient Signature:

Signature of legal guardian or authorized representative: