Welcome!

On behalf of Dr. Barbara Wu, we would like to welcome you to our dental practice. From the moment you walk in, our enthusiastic, skilled team will focus on providing you with the highest quality dental care. We understand that every individual is different, and we will customize your treatment to fit your unique smile.

During your first visit, a thorough oral exam will be done including necessary x-rays and full periodontal assessment. Enclosed is a health questionnaire for you to complete and bring to your first visit. To help make the visit as complete as possible, please bring any dental insurance information you may have. Thank you for choosing us and we look forward to meeting you soon!

Sincerely,

Dr. Barbara Wu

OFFICE POLICY
OF
DR BARBARA WU

Thank you for choosing us for your dental care. We are committed to providing you excellent care, and believe understanding office policies helps with successful treatment.

HIPPA

All health information obtained by you is private. No information is shared unless necessary to other health professionals in order to provide quality care for you. I understand these policies ____

Appointments

Your appointment time is reserved specifically just for you. Please be advised that our office charges for missed appointments unless they are cancelled *48 hours* in advance during business hours, **Monday, Tuesday, Thursday, for now.**

Payment of Services

Payment in Full is due at the time of service unless other prior arrangements are made. We accept MasterCard, Visa, Discover, American Express, and Personal Checks. We also work with Healthcare Creditline Dental for outside financing. For more information, please inquire within.

We accept most dental insurance plans. Our office is committed to helping you maximize your insurance benefits. Because the insurance policies vary greatly, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your estimate patient portion must be paid at the time of service.

Emergencies

Our office provides on/call service for emergencies 24 hours a day, 7 days a week. Call (408) 259-3383 and someone will contact you as soon as possible.

Should you have any questions or concerns, please talk to our office manager. Welcome to our office!

SIGNATURE-

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________________ Date _________ SS/HIC/Patient ID#____________
First Middle Initial Last

Address ________________________ City ________________ State _____ Zip _________

Sex: ❑ Female ❑ Male Birthdate __________ E-mail ______________________________

Home Phone (_____)__________ Cell Phone (_____)__________ Work Phone (_____)__________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School ___________________________ Occupation ________________

Employer/School Address ________________________ City __________ State ____ Zip ______

Spouse or parent's name ________________ Employer __________ Work Phone (_____)________

Whom may we thank for referring you to us? ______________________________

Person to contact in case of emergency ______________________ Phone (_____)__________

Responsible Party

Name of person responsible for this account ______________________________

Relationship to patient ______________________ Phone (_____) ________________

Address ______________________ City __________ State _____ Zip _________

Name of employer ______________________ Work Phone (_____)________________

Insurance Information

Name of insured ______________________ Relationship to patient ________________

Birthdate ______________ Social Security # ______________ Date employed ____________

Name of employer ______________________ Work Phone (_____) ________________

Address ______________________ City __________ State _____ Zip _________

Insurance Co. ________________Group #____________ Employer # ________________

Insurance Co. Address ____________________ City __________ State _____ Zip _________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured ______________________ Relationship to patient ________________

Birthdate _______ Social Security # ______________ Date employed ________________

Name of employer ______________________ Work Phone (_____)__

Address ______________________________

City ______________________State _____ Zip _________

Insurance Co. ______________________________

Group #______________________Employer # ________________

Insurance Co. Address ______________________________

City ______________________State _____ Zip _________

How much is your deductible? ______________________

How much have you used? ______________________

Max. annual benefit? ______________________

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Dental History

Name ______________________ Age ______ Date of last exam __________

Former Dentist______________________ Date of last dental X-rays __________

Reason for today's visit ______________________

How often do you brush?______________ How often do you floss? __________

Please check any of the following conditions that apply to you:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

Medical History

Physician ______________________ Date of last visit __________

Please list all medications you are currently taking: ______________________

Allergies: ______________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems Describe__________
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Have you ever taken any of these medications?

Diet Medications: ❑ Dexfenfluramine ❑ Fen-phen ❑ Pondimin ❑ Redux

Blood Thinners: ❑ Coumadin ❑ Warfarin

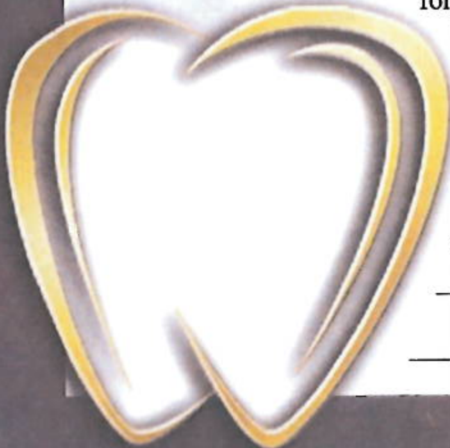
Other: ❑ Levoxyl ❑ Synthroid

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.



The above-named doctor may use my health care information and may disclose such information to the above-named 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 completed or one year from the date signed below.

______________________ Signature of Patient, Parent, Guardian or Personal Representative ______ Date

______________________ Please print name of Patient, Parent, Guardian or Personal Representative ______ Relationship