# *Steven K. Olsen D.D.S., Professional Corporation*

*Steven K. Olsen, D.D.S.*
*H. Kashani, D.M.D., M.S., M.S.*
*Russell S. Harris, D.D.S.*
*Albert Lam, D.M.D.*
*Shweta Prabhakar, D.D.S.*
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*Pil Han, D.M.D.*
*Gagandeep K. Pandher,D.D.S.*
*Michael Hwang, D.D.S.*

# Patient Information

Patient Info. Update

_____ _____
Date Initials

_____ _____
Date Initials

Date _____

Name _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____
Male _____ Female _____
Social Security # _____
Driver's License # _____
Married _____ Single _____
Employer _____
Address _____
_____
Position _____

Cell Phone # _____
Work # _____
Home # _____
Email Address _____

**Spouse / Partner Information**

Name _____
Phone _____
Address _____
_____

**Who may we thank for referring you?** _____

If you have Dental Insurance, please provide the following information so we can assist you in billing your dental insurance carrier:

## Primary Carrier

Name of Insured _____
Patient Relationship to Insured _____
SS # or Member ID_____
Insurance Carrier _____
Employer _____
Group # _____

## Secondary Carrier

Name of Insured _____
Patient Relationship to Insured _____
SS # or Member ID_____
Insurance Carrier _____
Employer _____
Group# _____

## General Information

Convenient Appointment Time _____
Are you available for appointments on short notice?
_____ Time of day _____
Person to contact in case of emergency:
_____
Their Telephone _____

Person Responsible for Account _____
_____
Relationship to patient _____
Driver's License # _____

**<u>Please Fill Out Both Sides Of The Form</u>** ⇨

## Medical History

Please Answer All Questions

**Please circle <u>Yes</u> or <u>No</u> to the following:**

| | | | If Yes, Explain: |
|---|---|---|---|
| Rheumatic Fever | NO | YES | _____ |
| Heart Murmur | NO | YES | _____ |
| High Blood Pressure | NO | YES | _____ |
| Circulation Problems | NO | YES | _____ |
| Excessive Bleeding | NO | YES | _____ |
| Hepatitis | NO | YES | _____ |
| Venereal Disease | NO | YES | _____ |
| AIDS | NO | YES | _____ |
| Anemia | NO | YES | _____ |
| Diabetes | NO | YES | _____ |
| Kidney Disease | NO | YES | _____ |
| Respiratory Disease | NO | YES | _____ |
| Tuberculosis | NO | YES | _____ |
| Sinus Problems | NO | YES | _____ |
| Asthma | NO | YES | _____ |
| Hay Fever | NO | YES | _____ |
| Ulcers | NO | YES | _____ |
| Arthritis | NO | YES | _____ |
| Tumors or Growths | NO | YES | _____ |
| Radiation Treatment | NO | YES | _____ |
| Fainting Spells | NO | YES | _____ |
| Nervous Disorders | NO | YES | _____ |
| Epilepsy | NO | YES | _____ |
| Head/Neck Injuries | NO | YES | _____ |
| Stroke | NO | YES | _____ |

Are you in good health? _____
Date of last medical exam _____
Have you ever been hospitalized? _____
If yes, what was the reason _____
_____
Do you wear a cardiac pacemaker? _____
Are you under the care of a physician?
_____
If so, for what? _____
_____
Are you pregnant? _____
How many months? _____
List any drugs or chemicals you are
Sensitive to _____
Any allergies to latex? _____
List any drugs you are now taking: _____
_____
Have you ever taken Bisphosphonates? _____
_____
Have you ever taken Fen-Phen? _____
Physician's Name _____
_____
Do you have any other disease, problem
or condition that you think the Doctor
should know about? _____
_____
Do you smoke? _____ If yes, how many packs
a day and for how long? _____
Do you drink Alcohol? _____ If yes, what is
your weekly intake? _____

## Dental History

(Please Answer All Questions)

When was the last time you saw a Dentist? _____
Have you ever had an unfavorable experience with a Dentist?
_____
_____
Is there anything we can do to make you feel more comfortable
while receiving treatment? _____
_____
_____
_____ Nitrous Oxide
When were your last set of x-rays taken? _____
Have you been instructed in the care of your gums? _____
Have you been treated for periodontal (gum) disease?_____

Do you grind or clench your teeth? _____
Have you ever had popping or clicking near
your ear when you chew? _____
Have you had orthodontic treatment?
(example: braces or invisalign) _____
Do you, or have you had any dental disease
problem's or condition that hasn't been
mentioned? _____
Please explain: _____
Do you have any sores, blisters, or swelling on
your gums, lips, or cheeks?_____

**I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this form.**

**Patient or Guardian's Signature: _____ Date: _____**

I certify that I have reviewed the medical history with the patient: _____

03/2021 *Doctor's Signature*

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## ---------- *Financial and Insurance Policy* ----------

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial and Insurance Policy is important to our professional relationship.

* All patients must complete the "Patient Information & Medical Form" before seeing the Doctor.
* Full payment is due at the time of service unless other arrangements are made.
* Twenty four hour notice is required when re-scheduling or canceling appointment.
* For your convenience, we accept: CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

We also offer Third Party Financing through: LendingClub or Care Credit.

### MONTHLY STATEMENTS

A monthly statement with current charges and payments, including insurance billings and payments will be sent to you. Pending estimated insurance benefits will appear on your statement until we receive payment from your insurance company. Billing Fees of 1.5 % per month are added to all unpaid balances after 90 days from date of service.

Should legal action be required to obtain payment, the undersigned patient/responsible party agrees to pay court costs and attorney fees.

### INSURANCE ASSIGNMENT

As a convenience to you, we will be happy to submit your insurance claims. The insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges incurred are your responsibility. Please keep your insurance information current by notifying us in writing of any changes in employment, insurance coverage, etc.

I have read, understand and agree to the above. I hereby authorize "Steven K. Olsen D.D.S., Professional Corporation", to submit and to sign insurance claims on my behalf. I hereby authorize the release of any information, pertinent to my case, to my insurance company or their agents. I understand that this authorization is a direct assignment of my rights and benefits under my policy and that payment will be made directly to "Steven K. Olsen D.D.S., Professional Corporation".

Patient / Responsible Party _____ Date _____
SIGNATURE

03/2021

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# TREATMENT AUTHORIZATION

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**Date:** _____

**Patient's Name:** _____

**Address:** _____

_____

_____

**I hereby grant authority to Steven K. Olsen D.D.S., Professional Corporation, and or the dentist(s) in charge of my care, to administer treatment and such anesthetics as may be deemed necessary in the diagnosis and treatment of my case.**

**I acknowledge that I have been informed of possible risks and consequences of the proposed treatment and do authorize the above Doctor's to proceed.**

**Signed** _____ **Date** _____

***Must be signed by <u>patient, or guardian</u> if the patient is a minor or if the patient is physically or mentally incapable.**

03/2021

# *Steven K. Olsen D.D.S., Professional Corporation*

***Two Embarcadero Center, Promenade Level ♦ San Francisco, CA 94111 ♦ Tel. (415) 398-4400***

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# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH 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 law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our 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. This Notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

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 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.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**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.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**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 institution or law enforcement official 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).

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**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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you **$0.15 for each page, $16.00 per hour** for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**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 do, 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. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we 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 have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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.

**Contact Officer:** Jennelyn A. Zelnik **Telephone:** (415) 398-4400 **Fax:** (415) 398-1748 **Email:** jzelnik@embarcaderodentistry.com
**Address:** 2 Embarcadero Center, Promenade Level, San Francisco, CA 94111

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Name}

_____
{Signature} {Date}

**For Office Use Only**

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)