ANSON DENTAL STUDIO

WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date 03/18/2024

SS/HIC/Patient ID # 617-64-2913

Patient Name Wai Ming Ma

Address 3702 High Street

City Oakland

State CA Zip 94619

E-mail samuelma0709@gmail.com

Sex ☐ M ☐ F Age 74 Birthday 07/09/1949

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation Piano Teacher/ Semi-Retired

Patient Employer/School Self Employed

Employer/School Address n/a

Employer/School Phone _____

Spouse's Name _____

Birthday _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? Joanne Wong

Dental Insurance

Subscriber's Name _____

Relationship to Patient _____

Birthday _____ SS# _____

Insurance Co. _____

Group # _____ Phone _____

In patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthday _____ SS# _____

Insurance Co. _____

Group # _____ Phone _____

Phone Numbers

Home Phone (415) 640-5436 Work Phone _____ Ext ____ Cell Phone (415) 640-5436

Spouse's Work _____ Best time and place to reach you Daytime Cell Phone okay to leave detailed message **IN**

CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name Michael Cooper Relationship Friend

Home Phone (415) 640-5435 Work Phone _____ Ext ____ Cell Phone (415) 640-5435

Dental History

Reason for today's visit Modification of partial denture

Former Dentist Dr. Barry Liu

City/State Berkeley, CA

Date of last dental visit February 2024

Date of last dental X-ray February 2024

How often do you floss? Daily

How often do you brush? twice a day

Do you wear contact lenses? ☐ Yes ☐ No

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or check biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning Sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

Medical History

Physician's Name Samantha Malm, MD Date of last visit 08/01/2023

Phone (510) 204-5600 Pharmacy Walgreens, High St, Oakland CA Phone (510) 261-1984

Please check (☑) "Yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problem	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	**Have you ever had or been diagnosed with:**		
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Artifical Joints, Screws, Pins, etc.	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Hernia Repair	☐ Yes	☐ No
			Skin Rash	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Special Diet/Weight Loss	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No			
Heart Problems	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No	**Are you allergic to:**		
Hepatitis Type _____	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Herpes	☐ Yes	☐ No				Barbiturates	☐ Yes	☐ No
			Have you ever taken any of these medications?			Codeine	☐ Yes	☐ No
			Bisphosphonates	☐ Yes	☐ No	Ibuprofen	☐ Yes	☐ No
			Blood Thinners	☐ Yes	☐ No	Latex	☐ Yes	☐ No
			Coumadin	☐ Yes	☐ No	Local Anesthesia	☐ Yes	☐ No
			Warfarin	☐ Yes	☐ No	Metals (i.e. gold)	☐ Yes	☐ No
			Diet Medications	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
			Dexfenfluramine	☐ Yes	☐ No			
			Fen-phen	☐ Yes	☐ No			
			Pondimin	☐ Yes	☐ No			
			Redux	☐ Yes	☐ No			
			Levoxyl	☐ Yes	☐ No			
			Synthroid	☐ Yes	☐ No			

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If Yes, please describe _____

One time had excessive bleeding after extraction

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If Yes, please describe _____

Tricuspid and pulmonary valve replacements. Feel well now

Women: Are you pregnant? ☐ Yes ☐ No

Due date 00/00/0000

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Other Strawberries

Please PRINT all medications now taking: _____

ELIQUIS, LEVOTHYROXINE, PANTOPRAZOLE, LISINOPRIL, METOPROLOL, BENADRYL AND CLINDAMYCIN BEFORE DENTAL PROCEDURES

SIGNATURES

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.

Insurance Assignment: I certify that I, and/or my dependent(s), have Insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

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.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. _____ to use and/or disclose my Protected Health Information (PHI) related to _____
Name of Doctor Disclosing PHI Describe in detail the Protected Health Information

_____,. The information will be used and/or disclosed for the purpose of _____
you are authorizing to be used and/or disclosed. Describe in d each purpose for which you are authorizing

_____. I authorize Dr. _____ to receive and use the information.
your Protected Health Information to used and/or disclosed. Name of Doctor Receiving PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be redisclosed by the recipient and may no longer be protected by federal privacy regulations, I understand that I may revoke this authorization at any time by notifying. In writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ 00/00/0000
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Doctor's Comments and update

Medical Clearance Letter Sent to _____ Date 00/00/0000

Results _____

Signature _____ Date 03/18/2024

ANSON
DENTAL STUDIO

5286 Iron Horse Parkway Suite A
Dublin, Ca 94568
(925) 587-1584

Office Policy Statement

Welcome to our office. We are pleased that you have selected our office. We find that communication with our patients regarding our office policy assists us in providing the best service to you and helps avoid misunderstandings. Please sign at the bottom that you recognize and agree to these terms. Please feel free to ask us any questions.

Dental Insurance

We are happy to help you file the necessary forms to insure that you receive the full benefits of your policy; HOWEVER we can make no guarantee of any estimate coverage. Your co-payment is due on the date of services rendered. Your insurance policy is an agreement between you, your employer and your insurance company. We ask that all patients be responsible for services rendered in this office. Services provided must be paid for at the time of treatment. There is an interest rate charged of 1½ % per month to any account that is 45 days past due.

Appointments

We respect your appointment time and take every effort to begin your treatment as scheduled. We request at least 48 hours notice to allow another patient to use the time that had been set aside for your visit. Failure to let us know of your cancellation 48 hours in advance will result in a $50.00 charge per hour to you.

Returned checks and Collection action

If a check is returned to us for insufficient funds, a $25.00 service fee charge will be applied to your account. IF you are forwarded to our collection agency, you will be responsible for all charges, including interest, late charge fees, collection fees, and attorney's fee.

Thank you for taking the time to read this policy statement.

I (we) have read, understand, and agree to the above policy.

Responsible Party/Patient: YES

Date: 02/18/2024

ANSON DENTAL STUDIO
5286 Iron Horse Parkway Suite A
Dublin, Ca 94568
(925) 587-1584

Privacy Practices Acknowledgement

Acknowledgement Form

I received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name Wai Ming Ma _____ Birth Date 07/09/1949 _____

Signature _____

Date 03/18/2024 _____