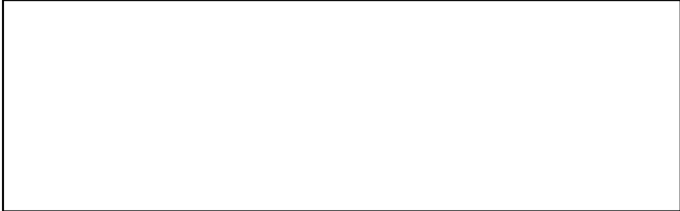
University of California
San Francisco

Fresno Medical Education Program

ORAL & MAXILLOFACIAL SURGERY

ROBERT S. JULIAN III, DDS, MD, INC.
BRIAN M. WOO, DDS, MD, INC.
CRMC – Ambulatory Care Center
290 N. Wayte Lane * Fresno, CA 93701-2124
Phone: (559) 459-4101 * Fax: (559) 459-5744



PATIENT REGISTRATION INFORMATION

(PLEASE PRINT THROUGHOUT ALL 5 PAGES)

PATIENT/FAMILY INFORMATION **TODAY'S DATE:** ____________________

PATIENT NAME: ____

☐ MALE ☐ FEMALE DATE OF BIRTH: _____/_____/_____ AGE: ____________________
(mo) (day) (year)

ADDRESS: ____APT: _____ CITY, STATE & ZIP: ____________________

HOME PHONE: ( ) ______________ BUSINESS PHONE: ( ) ______________ SOCIAL SECURITY #: ____________________

EMPLOYER: ______________________________ OCCUPATION: ______________________________

EMPLOYER'S ADDRESS: ______________________________ CITY, STATE & ZIP: ______________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME: ______________________________ DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: ______________

ADDRESS: ______________________________________ CITY, STATE & ZIP: ______________________________
(if different than above)

EMPLOYER: __________________________ OCCUPATION: ____________________ WORK PHONE: ( ) ______________

EMPLOYER'S ADDRESS: ______________________________ CITY, STATE & ZIP: ______________________________

PHYSICIAN: ________________________________ DENTIST: ________________________________

OTHER DENTAL SPECIALIST (i.e., Orthodontist, Periodontist): ____

OTHER MEDICAL SPECIALIST (i.e., Ear/Nose/Throat, General Surgery, etc.): ______________________________________

REFERRED TO OUR OFFICE BY: ____

NEAREST RELATIVE OR FRIEND
FRIEND NOT AT SAME ADDRESS: ______________________________ PHONE: ( ) ____________________

ADDRESS: ______________________________________ CITY, STATE & ZIP: ______________________________

WHY ARE WE SEEING YOU TODAY? ☐ CONSULTATION ☐ JAW PROBLEM
☐ TOOTH REMOVAL ☐ FACIAL INJURY ARE YOU HAVING PAIN NOW? ☐ YES ☐ NO

ARE YOU BEING SEEN DUE TO A WORK RELATED INJURY? ☐ YES ☐ NO

IF YES, WHERE AND WHEN DID IT HAPPEN? ____

EXPLAIN HOW IT HAPPENED: ____

MEDICAL/DENTAL INSURANCE INFORMATION

PLEASE PROVIDE DENTAL INFORMATION

Primary insurance company name: ______________________________ Group #: ______________

Address to mail claim to: __________________________ City, State & Zip: ______________________

Name of insured person: ___________________________________ Date of Birth: ______________

Social Security#: ________ - ______ - ________ Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Second insurance company name: ______________________________ Group #: ______________

Address to mail claim to: __________________________ City, State & Zip: ______________________

Name of insured person: ___________________________________ Date of Birth: ______________

Social Security#: ________ - ______ - ________ Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

PLEASE PROVIDE MEDICAL INFORMATION

Primary insurance company name: ______________________________ Group #: ______________

Address to mail claim to: __________________________ City, State & Zip: ______________________

Name of insured person: ___________________________________ Date of Birth: ______________

Social Security#: ________ - ______ - ________ Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Second insurance company name: ______________________________ Group #: ______________

Address to mail claim to: __________________________ City, State & Zip: ______________________

Name of insured person: ___________________________________ Date of Birth: ______________

Social Security#: ________ - ______ - ________ Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

I authorize the release of any information pertaining to this claim. **I understand that I am financially responsible for all costs of treatment.** I authorize payment of benefits directly to the doctor. In the event that my insurance contract calls for direct payment of benefits to me, I authorize and request that the check be mailed to me as follows: c/o Robert Julian III, DDS, MD, Inc. or Brian M. Woo, DDS, MD, Inc.; 290 N. Wayte Lane, Fresno, CA 93701-2124.

______________________________ ______________________________
SIGNATURE (Patient or Guardian) Date

______________________________ ______________________________
Insured Signature Date

PATIENT HEALTH HISTORY

Have you ever been treated for any of the following? *(Circle yes or no)*

Condition				Condition		
Rheumatic Fever…………......................	YES	NO		Epilepsy…………………………...	YES	NO
Rheumatic Heart Disease………………..	YES	NO		Stroke……………………………...	YES	NO
Heart Trouble (Coronary)……………….	YES	NO		Glaucoma………………………….	YES	NO
Heart Murmur…………………..............	YES	NO		Hepatitis…………………………...	YES	NO
Angina (Chest Pain)…………………….	YES	NO		Tuberculosis……………………….	YES	NO
Hypertension (High Blood Pressure)….....	YES	NO		Asthma…………………………….	YES	NO
Do your ankles swell?..............................	YES	NO		Hay Fever…………………………	YES	NO
Anemia…………………………………..	YES	NO		Shortness of Breath………………..	YES	NO
Diabetes…………………………………	YES	NO		Ulcers or Frequent Indigestion……	YES	NO
Kidney Disease………………………….	YES	NO		Cancer……………………………..	YES	NO
Liver Disease……………………………	YES	NO		Sinus Trouble……………………...	YES	NO
HIV (AIDS)……………………………..	YES	NO		Jaws pop/click (TMJ)……………..	YES	NO

Have you ever had a serious illness or have you been in a hospital YES NO
If yes, WHAT and WHEN?

____

____

Have you been under the care of a physician during the last two years? YES NO
If yes, FOR WHAT CONDITION?

____

____

Have you taken any drugs or medicines in the last year or are you taking any now? YES NO
If yes, WHAT?

____

____

Are you allergic to any drugs or medicines? YES NO
If yes, WHAT?

____

____

Have you ever had excessive bleeding following a cut, extraction, or surgery? YES NO
If yes, HOW LONG?

____

Are you pregnant now? YES NO Are you taking birth control pills? YES NO
Are you wearing contact lenses? YES NO

SIGNATURE OF PERSON COMPLETING THIS HEALTH QUESTIONNAIRE:

_______________________________ _______________________________
SIGNATURE (Patient or Guardian) Date Updated Date

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GENERAL CONSENT FOR OMFS CONSULTATION OR TREATMENT

____

Patient Name Date

1. I hereby authorize Robert Julian, DDS, MD, Inc. or Brian Woo, DDS, MD, Inc., i.e., OMFS Care Center at CRMC Ambulatory Care Center to perform any necessary diagnostic, examination, and x-ray procedures that they deem necessary for the evaluation of my dental and/or oral-maxillofacial condition, including photographs. _______

2. I understand that anesthetics, diagnostic, and therapeutic procedures all may involve calculated risks of complications and injuries, from both known and unknown causes and no warranty or guarantee has been made as to result or cure. The risks, alternatives, and benefits will be explained to me using conventional or unconventional language, all questions will be answered, and after I truly understand the details and freely consent will treatment be performed. _______

3. After the doctor has diagnosed any acute dental and/or oral-maxillofacial condition that requires emergency treatment, that will be explained to me, I hereby authorize and direct Robert Julian III, DDS, MD, Inc. or Brian Woo, DDS, MD, Inc., i.e., OMFS Care Center at CRMC Ambulatory Care Center to perform those emergency procedures. _______

4. I understand and accept that any patient ***without*** insurance coverage is required* to pay a deposit of $95.00 towards the treatment to be performed. This amount is only a **deposit**, and I will be financially responsible for the cost of all services rendered. Those *foreseen* charges will be presented to me prior to treatment, and after I truly understand the details and freely consent, will treatment be performed. (*Medical Clearance Patients may be excluded). All co-payments or Share of Cost amounts must be paid as designated by your insurance plan and/or policy prior to treatment. _______

I have read, initialed, understand and agree to the consent items listed above. I hereby authorize and direct Robert Julian III, DDS, MD, Inc., or Brian Woo, DDS, MD, Inc., i.e., OMFS Care Center at CRMC Ambulatory Care Center to provide such additional services for me as is deemed reasonable and necessary.

____

Signed (parent or guardian, if a minor) Date

____

Witness Date

PRIVACY POLICY ACKNOWLEDGEMENT
REGARDING YOUR PERSONAL HEALTH INFORMATION

Federal law, Health Insurance Portability and Accountability Act (HIPPA), now requires us to request from you an agreement that we can disclose personal health information, such as your dental health or general health, to authorized parties. These may include such entities as your other dentists, physicians, related pharmacies, and your insurance carriers.

The UCSF OMFS Residency Program, Robert Julian III, DDS, MD, Inc. or Brian M. Woo, DDS, MD, Inc. will not make available any personal health information to any other persons without your specific prior written consent. We will honor any request from you to limit the exchange of information about your health condition if we are able to do so without impairing our ability to provide good medical care. We each retain the right to terminate our professional relationship if we disagree on this policy.

Your signature below indicates that you have read and understand this Privacy Policy.

_______________________________________ _______________________________

Patient or Personal Representative Signature Date

____

Personal Representative's Relationship to Patient

ABOVE - Patient or Personal Representative Use Only

Documentation of Good Faith Effort

The patient identified above was given an opportunity to review the Privacy Policy of the UCSF OMFS Residency Program - Robert Julian III, DDS, MD, Inc. - Brian M. Woo, DDS, MD, Inc., a good faith effort has been made to obtain a written acknowledgement from the patient; however, acknowledgement has not been obtained because:

☐ Patient declined to sign the Privacy Notice Acknowledgment because:

____

☐ Patient was unable to sign because:

____

☐ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

____

☐ Other reason described below:

____

_______________________________________ _______________________________

Employee Signature Date