

# GOLDEN COAST DENTAL

Office of Jun Wu, DDS. Inc.

15034 Foothill blvd, Suite #A, Fontana, CA 92335

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Preferred Name

Male

Female

Marital Status:

Single

Married

Child

Other

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Soc Sec Number

\_\_\_\_\_  
Driver's License

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Secondary Email Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work

\_\_\_\_\_  
Cell

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Employer Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Employer Phone

\_\_\_\_\_  
Employer Secondary Phone

EMERGENCY CONTACT: (Relative or Friend, not living with you.)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
Cell Phone

Whom may we thank for referring you to us? \_\_\_\_\_

I, \_\_\_\_\_ authorize Jun Wu, DDS to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Jun Wu, DDS. I authorize Jun Wu, DDS to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is Jun Wu, DDS's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

\_\_\_\_\_  
Signature of Patient or Legal Representative Witness

\_\_\_\_\_  
Date

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

As a courtesy to our patients, we would like to know the following things about you.  
Please check all that apply:

- I gag easily.
- I feel out of control when I'm lying down in the dental chair.
- I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- Pain relief is a top priority for me.
- I don't like shots (or I've had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive.
- I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- Please respect my time. I don't want to be left sitting in the reception area.
- I want to know the cost up front. No money surprises please.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.

I prefer:

- to learn every detail of my care.
- just an overall explanation.
- to let my dental benefits company coverage control my care.
- let my doctor control my care.

Please tell us the primary reason for today's visit and/or concerns you want to discuss with the dentist: \_\_\_\_\_

\_\_\_\_\_

# GOLDEN COAST DENTAL

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## Our Financial Policy

WELCOME! Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. This will allow you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's health and self-esteem. We are committed to providing you with the best possible dental care and to keeping you informed of treatment recommendations and financial obligations.

The following are our office policies:

- Payment is due at the time services are rendered. We accept cash, checks, and all credit cards. To make dental treatment affordable, we also offer payment plans.
- If you have dental benefits, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated payment. Because the dental benefits policy is an agreement between you and your benefits company, you are responsible for all charges. After your initial exam, you will receive a treatment plan which estimates your portion of payment. If we collect an estimated co-payment and your dental benefits company underpays or denies a benefit, you are responsible for the remaining balance. Please know that we will do everything possible to see that you receive the full benefits of your policy.
- Some services may not be covered by your dental benefits company. The doctors make their recommendations based on their knowledge of what is best for your oral health, not on what your benefits will cover. Please don't allow the insurance company to determine what is best for you.
- Your appointment is time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice to avoid a \$75.00 cancellation fee. If you miss an appointment without notifying our office, you will be required to pay 50% of the value of your next appointment (non-refundable) before scheduling. If you miss more than one scheduled appointment without notifying us, you will be dismissed. We appreciate your understanding of how important keeping appointments are to the doctor and our other patients.
- A fee of \$85.00 and a signed Release Request form are required for duplicating x-rays requested by patient.
- Returned checks are subjected to a \$25 charge. Outstanding balances over 30 days are subject to collection fees and an interest rate of 1.75% per month.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and therefore have more time to dedicate to your dental care. If you have any questions regarding the above information or dental benefits coverage, please do not hesitate to ask. We are here to help!

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Signature

Date

**GOLDEN COAST DENTAL**

Office of Jun Wu, DDS. Inc.

15034 Foothill Blvd, Suite #A, Fontana, CA 92335

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

**PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.**

We now offer the following payment options:

- Payment by cash or check
- Payment by credit card
- Automatic monthly billing to your credit card
- Guarantee any amount not covered by dental insurance with credit card
- CareCredit® – patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With CareCredit, you enjoy these benefits:
  - Flexible financing options
  - No annual fees or prepayment penalties
  - Quick and easy application
  - Receive a credit decision almost immediately
  - Start your recommended treatment immediately

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your credit card to automatically cover amounts not paid by your dental benefits. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis.

If none of the above applies, please see the office manager. Thank you.

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Print Name

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Signature

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Date