

SHIEH & LUO DENTAL GROUP
Family & Implant Dentistry
801 Woodside Road Suite#3, Redwood City, CA 94061
(650)365-4626 redwoodadvanceddentalcare@gmail.com

PATIENT INFORMATION RECORD

13 years or under?

Today's Date 今天的日期 _____

Name 姓名 _____ Preferred 我喜歡使用的名字 _____
Mr. Mrs. Ms. Dr. Last name 姓 First 名 Middle 中間名

Birthdate 出生日期 _____ **SSN** 工卡號碼 _____ / _____ / _____ **Driver's License #** 駕照號碼 _____

Address 住址 _____
Street 街名 Apartment # 公寓 # City 城市 State 省 Zip 郵區號碼

Phone 電話號碼 () _____ **Cell** 手機號碼 () _____ **Text ok?** 可以發送短信嗎? • Yes • No

E-mail: 電子郵件地址 _____ @ _____ **Appt emails ok?** 可以發送電子郵件? • Yes • No

Sex 性別: • M 男 • F 女 **Marital Status (optional):** • Single 單身的 • Married 已婚 • Other 其他

Name of Person Responsible for Account 負責帳戶人的姓名 _____ **Relationship to Patient** 關係 _____

Employer 雇主 _____ **Occupation** 工作 _____ **Work Phone** 工作電話號碼 () _____

Work Address 工作地址 _____ **City** 城市 _____ **State** 省 _____ **Zip** 郵區號碼 _____

Referred by 轉介人的姓名 _____ **Relationship** 關係 _____

Emergency Contact 在緊急情況聯絡人姓名 _____ **Phone** 電話號碼 () _____

INSURANCE INFORMATION 保險資料

Insured's Name 有牙科保險人的名字 _____ **SS#** 工卡號碼 _____ / _____ / _____ **Birthdate** 出生日期 _____

Subscriber's Employer Name and Address 雇主 _____ 電話號碼 () _____

Ins Co 牙科保險公司的名稱 _____ **Group #** _____ 電話號碼 () _____

Secondary Insurance? 你有沒有其他牙科保險? • Yes 有 • No 沒有 _____

*****OFFICE POLICIES: If you are unable to keep an appointment, please provide 48 hours advance notice so that the time may be given to another patient. We understand that emergencies do arise; however, **cancellations without 48 hour notice and broken appointment may result in a charge of \$50.00 per hour.**

I, the undersigned patient and / or insured, have been informed of the treatment, materials and associated fees. I, in requesting examination and treatment on myself or my dependent, consent and authorize the release of all the information to any Health Service Plan or Insurance company I designate to Lei Luo, D.D.S. I hereby authorize and direct payment of the dental benefits directly to Lei Luo, D.D.S. otherwise payable to me.

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics &/or x-rays, deemed necessary by the dentist. I understand that the total fee for dental services is my responsibility, regardless of what benefits I do or do not receive from my insurance company. I also understand that payment is expected at the time of service, unless financial arrangements are made in advance; and that all overdue accounts may result in late fees and finance charges.

Patient's or Legal Guardian's Signature 簽名 _____ **Name (print)** _____ **Date** 日期 _____

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DENTAL HISTORY 牙科資料

Smoking Habbit有吸烟的习惯吗? _____ How many a day一天大概多少? _____

Last visit 最後一次訪問牙醫 _____ Last x-rays 最後一次牙科X光 _____

Former Dentist 以前的牙醫姓名 _____ 電話號碼() _____ Bleeding gums? 你的牙肉會流血嗎? • Yes 是 • No 否

TMJ pain? 你的顎關節(顳下頷關節)有沒有過? • Yes 是 • No 否 Abx proph? 牙科治療之前,你必須使用抗生素嗎? • Yes 是 • No 否

Want whiter teeth? 你想漂白牙齒嗎? • Yes 是 • No 否 How often do you floss? 你每個星期用牙線幾次? _____

How often do you brush? 你每天刷牙幾次? _____

Had any of the following 請選擇你有過的治療? • Wisdom Teeth Surgery 智慧牙手術 • Braces 牙齒矯正 • Gum 牙肉手術 • Denture 假牙

Grind? 你磨牙嗎? • Yes 是 • No 否 Problems with previous dental work? 你以往的牙科治療有沒有問題? • Yes 有 • No 沒有

MEDICAL HISTORY 醫療資料

Physician 醫生的姓名 _____ Phone 電話號碼() _____ Fax傳真號碼() _____

Address 地址 _____ Date of last visit 最後一次見醫生 _____

*Preferred pharmacy 药房 _____

*Address 地址 _____

Are you currently under the care of a physician due to an illness? 你現在有**其他**疾病見醫生嗎? • Yes 有 • No 沒有

*Are you taking any prescription/ over-the-counter or herbal supplement drugs? Please list each one: _____ 你現在有沒有服用任何藥 或 處方藥 或 草本藥 或 補充藥物? • Yes 有 • No 沒有 如果有, 請說明: _____

*Please indicate with a check mark ☑ if you ever had taken any of the following: 請選擇☑下列任何你有服用過的藥物:

• Fosamax, Boniva, Actonel 骨質疏鬆藥? (也稱為 bisphosphonates) • Phen-Fen 減肥藥? (也稱為 redux 或 pondilmin)

• Blood Thinners 血液稀釋劑藥? (Aspirin, etc.)

For women: 婦女們: Are you taking birth control pills? 你是否服用避孕藥? • Yes 是 • No 否

Are you pregnant or nursing? 你是否懷孕或哺乳? • Yes 是 • No 否

Are you allergic to any of the following? 你對以下任何藥物或東西過敏嗎?

- | | | |
|----------------------------|---------------------|------------------------------------|
| • Aspirin 阿司匹林 | • Metals 鐵 或 鎳 或 金屬 | • Epinephrine (over reaction) 腎上腺素 |
| • Codeine 可待因 | • Penicillin 青黴素 | |
| • Dental anesthetics 牙科麻醉劑 | • Sulfa 磺胺 | |
| • Erythromycin 紅黴素 | • Tetracycline 四環素 | • Other 其他 _____ |
| • Jewelry 珠寶 | | |
| • Latex gloves 乳膠手套 | | |

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Please indicate with a check mark if you ever had any of the following: 請選擇下列任何你有過的疾病或醫療問題:

• Abnormal bleeding 異常出血*	• Heart Conditions/Diseases/ Surgeries 心脏病/心臟手術*	• Thyroid Problems 甲狀腺問題
• Alcohol/drug abuse 濫用酒精 / 藥物	• Hepatitis 肝炎	• Rheumatic / Scarlet Fever 風濕熱/猩紅熱
• Anemia 貧血	• Herpes/Fever Blisters 皰疹 / 熱水泡	• Liver Disease 肝病
• Arthritis /Rheumatism 關節炎 / 風濕病	• High Blood Pressure 血壓高	• Seizures 抽搐
• Artificial heart valve 人工心臟瓣膜*	• HIV+ / AIDS 艾滋病	• Shingles 帶狀皰疹
• Artificial joints/ bones 人造關節 /骨骼 *	• Hip Replacements/Knee Replacements 髖關節置換/膝關節置換*	• Sickle Cell Disease 鎌細胞疾病
• Asthma 哮喘	• Hospitalized 住院-以任何理由	• Colitis 結腸炎
• Back problems 背部疼痛	• Hemophilia 血友病	• Tobacco Use 吸煙/服煙草
• Blood transfusion 輸血	• Kidney Problems 腎臟問題	• Tuberculosis (TB) 肺結核
• Frequent Headaches 經常頭疼	• Low Blood Pressure 低血壓	• Ulcers 潰瘍
• Congenital Heart Defect 先天性心臟缺損	• Cancer/chemotherapy 癌症化療	• Venereal Disease 性病
• Cortisone treatments 可的松治療	• Mitral Valve Prolapse 二尖瓣脫垂	• Glaucoma 青光眼
• Diabetes 糖尿病	• Infective endocarditis 感染性心內膜炎	• Hay Fever 花粉症
• Difficulty Breathing 呼吸困難	• Pacemaker 心臟起搏器* Heart Stent 心脏支架橋*	• Heart Attack 心脏病發作*
• Emphysema 肺氣腫	• Psychiatric Problems 精神問題	• Heart Murmur 心雜音*
• Fainting Spells 昏厥	• Sinus Problems 鼻竇問題	• Frequent Headaches 經常頭疼
• Osteoporosis 骨質疏松症*	• Stroke 中風*	

The above information is accurate and complete to the best of knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my medical status.

我已經盡我所知回答上述問題。如果我有任何身體狀況或藥物改變,告知我的牙醫是我的責任。

Patient's Signature 簽名 _____ Name (print) _____ Date日期 _____

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Financial Policy/Patient Financial Agreement

The Lei Luo DDS is committed to serving our patients with professionalism, care and concern. We expect the same commitment from our patients. This includes being on time for your appointments and calling to cancel an appointment in advance if you can't make it. This commitment also includes financial responsibilities, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Lei Luo DDS will file your insurance claim for you.

For services rendered outside of our office, like radiology, certain laboratory tests, surgery centers, physical therapy, hospitals and rehabilitation centers, it is YOUR responsibility to know which facility you are required to use. If you aren't sure, please speak with your insurance member services or one of our staff before scheduling.

I understand that my signature authorizes payment to be made to pay my claim. My signature also authorizes the release of dental information necessary to file claims with any secondary insurance payer.

I have read and understand Lei Luo DDS's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Name: (print) _____

Signature: _____ Date: _____

诊所财务协议

Lei Luo DDS 的目标是提供和保持良好的客户关系。提前让你知道我们的办公室政策允许一个良好的沟通流程,使我们能够实现我们的目标。我们希望我们的患者做出同样的承诺。这包括准时参加约会, 如果无法参加, 则提前打电话取消约会。此承诺还包括财务责任, 例如在每次约会时出示身份证和保险卡, 并在您访问时用现金, 支票或信用卡支付共付额和自付额。

到达时,请在前台签到,并在每次访问时出示您当前的保险卡。您将被要求签署和日期 的文件副本的卡。这是你对正确的保险的验证, 并同意向他们提出法案。如果您指定的 保险公司是不正确的, 您将负责支付的访问和提交的费用, 改为正确的计划。如果你没有保险,在访问时支付医院的会诊费。

对于在我们诊所以外提供的服务, 例如 实验测试, 手术中心, 物理治疗, 医院和康复中心, 您有责任清楚知道您的需要和设施。如果您不确定, 请在牙齿治疗的日程之前与您的保险会员服务部或我们的工作人员交谈。

我已经阅读并理解了这个诊所的财务政策,并同意遵守和接受的责任,并同意遵守及承担任何在到期前支付的款项。

签名: _____ 日期: _____

姓名: _____

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NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed, as well as how you can access this information.

At our dental office, we always keep the health information of our patients secure and confidential. A new law requires us to continue maintaining that privacy, to give you this notice and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment for example: We may use or disclose your health information for payment of your services. We may use or disclose your information with our business associates, such as a collection agency. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. We may also want to call and remind you about your appointment. In case of an emergency, we may disclose your health to a family member or another person who is responsible to your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without prior written authorization. You may request in writing that we do not use or disclose your health information without your prior written authorization. You have the right to transfer copies of your health information, with a few exceptions. We will charge you a fee of \$50.00 per copy. You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing. You have the right to receive a copy of this notice without any charges. If we change any of the details of this notice, we will notify you of the changes in writing.

Acknowledgement: I have read and understand this notice of privacy practices.

Sign: _____ Date: _____

Print Name: _____

If signed as a parent or guardian, please print the name of the patient: _____

隱私條例通知

此通知將闡述您的醫療信息如何被使用及披露，及您如何獲得相關信息。

我們診所一律保密病人的信息不被洩露。目前一項新的法律要求我們繼續保持病人信息的私密性，并讓您獲知這項條例。此條例允許我們將您的醫療信息披露給參與醫療過程的各方。例：出於付款的目的，我們會使用或披露您的醫療信息。我們會公開您的信息給第三方合作夥伴，如欠款代收公司。我們與第三方簽訂了書面合同，要求他們同樣保護您的隱私。我們會查看您的信息來聯繫您，譬如打電話給您或提醒您有醫生預約。如有緊急情況發生，我們或會向您的家庭成員或照顧您的人披露醫療信息。如法律要求，我們會披露您的醫療信息。如果診所售予他人，您的信息將轉為他方財產。除以上所述，診所需要書面授權才會公開您的醫療信息。您可以書面要求我們未經允許不得披露任何信息。您有權傳送您的信息去他處，少數情況除外。每一份信息我們將收取\$50。您有權通過書面要求修改或更改您的醫療信息。無需額外收費，您有權獲取這份條例。如果這份通知有任何改變，我們會通過書面告知您。

確認書：我已閱讀并同意此通知。

簽名：_____ 日期：_____

姓名：_____

父母或監護人請簽名：_____