DR. LEI LUO, D.D.S

Family & Implant Dentistry

560 Jenevein Ave, San Bruno, CA 94066

(650)583-6032 leiluodds@att.net

PATIENT INFORMATION RECORD

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 _____ **SS**N 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 ( ) _____

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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

If Yes, please provide us with insurance name: _____

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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 Habit 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 _____ Phone Number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(顳下頜關節)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多次? _____

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

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 Do you 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

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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pondimin)
- ☐ Blood Thinners **血液稀释剂**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
- ☐ Codeine 可待因
- ☐ Dental anesthetics 牙科麻醉劑
- ☐ Erythromycin 紅黴素
- ☐ Jewelry 珠寶
- ☐ Latex gloves 乳膠手套
- ☐ Metals 鐵 或 鎳 或 金屬
- ☐ Penicillin 青黴素
- ☐ Sulfa 磺胺
- ☐ Tetracycline 四環素
- ☐ Other 其他 _____

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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 Surgery 心臟手术*	☐ 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	☐ Hospitalized 住院-以任何理由	☐ Sickle Cell Disease 鐮細胞疾病
☐ Asthma 哮喘	☐ Hemophilia 血友病	☐ Colitis 結腸炎
☐ Back problems 背部疼痛	☐ Kidney Problems 腎臟問題	☐ Tobacco Use 吸煙/服煙草
☐ Blood transfusion 輸血	☐ Low Blood Pressure 低血壓	☐ Tuberculosis (TB) 肺结核
☐ Cholesterol 胆固醇高	☐ Cancer/chemotherapy 癌症化療	☐ Ulcers 潰瘍
☐ Congenital Heart Defect 先天性心臟缺損	☐ Mitral Valve Prolapse 二尖瓣脫垂	☐ Venereal Disease 性病
☐ Cortisone treatments 可的松治療	☐ Infective endocarditis 感染性心內膜炎	☐ Glaucoma 青光眼
☐ Diabetes 糖尿病	☐ Pacemaker 心臟起搏器	☐ Hay Fever 花粉症
☐ Difficulty Breathing 呼吸困難	☐ Psychiatric Problems 精神問題	☐ Heart Attack 心脏病發作
☐ Emphysema 肺氣腫	☐ Sinus Problems 鼻竇問題	☐ Heart Murmur 心雜音
☐ Fainting Spells 昏厥	☐ Stroke 中風	☐ Frequent Headaches 經常頭疼

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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Informed Consent Form

1. **X-Rays**

I understand that a thorough dental exam usually requires an x-ray. Only those x-rays which are absolutely necessary for proper treatments will be taken. All measures for radiation protection and safety will be adhered to. (**Initials**: _____)

2. **Drugs and Medication**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/ or anaphylactic shock (severe allergic reaction). (**Initials**: _____)

3. **Fillings**

I understand that the most common complications to fillings are pain, sensitivity to temperature changes or foods, fracture of tooth structure, nerve damage, other damages to other teeth, occlusal(bite) discrepancies, TMJ complications, reactions to drugs or anesthesia. (**Initials**: _____)

4. **Change in Treatment Plan**

I understand that during treatment, there may be a need to change or all procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy, following routine restorative procedures. I give my permission to the Dentist to make any/ all changes and additions as necessary. (**Initials**: _____)

5. **Removal of Teeth**

Alternative to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc) and I authorize the Dentist to remove the following teet hand any other necessary for reasons #3. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paraesthesia) that can last for indefinite periods of time or fracture jaws. I understand I may need further treatment by a specialist or even hospitalization if complication arises during or following treatment, the cost of which is my responsibility. (**Initials**: _____)

6. **Crowns and Bridges**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily. I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. (**Initials**: _____)

7. **Dentures - Complete and Partial**

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those applications have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the “teeth in wax: try-in visit. I understand that most dentures may require rellining approximately 3-12 months after initial placement. The cost of this procedure is not included in the initial denture fee. (**Initials**: _____)

8. **Endodontic Treatment (Root Canal)**

I understand that there is no guarantee that root canal treatment will save my tooth and complications can occur from the treatment, and that occasionally metal objects are commented into the tooth to extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical producers may be necessary following root canal treatment (apicoectomy). (**Initials**: _____)

9. **Periodontal Loss (Tissue and Bone)**

I understand that I have a serious condition causing gum and bone inflammation or loss, and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me including gum surgery, replacement and/ or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (**Initials**: _____)

By signing this consent, you are also agreeing to accept full financial responsibility for any services rendered to you.This financial responsibility includes the entire account balance, or the percentage that your insurance does not cover. You understand that failure to pay this balance can result in your account balance and information being transferred to a collection agency. **I have read and fully understand all of the above matters.**

Patient Signature:_____ **Date**:_____

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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: _____

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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診所的财务政策,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:_____