REGISTRATION FORM 登記表格

Chart No.: _____

(1) PERSONAL DATA OF PATIENT 病人個人資料 PL: C E M Date: _____

Last Name | First Name | 中文姓名 | Date Of Birth | Age | Sex | Social Security No.

Address Street No. Apt. No. | City | State | Zip | □ Single 單身 □ Married 已婚

Home Phone | Work Phone | Cell Phone | Emergency Phone | Contact Person | Relationship

Who in your family has been here before? | Referred By | Email Address | Can we text you? □ Yes □ No

(2) PERSONAL DATA OF INSURSED (If patient is the insured person, leave this part empty.)
受保人個人資料 (如受保人是病人, 請將這部分留空)

Last Name | First Name | 中文姓名 | Date Of Birth | Age | Sex | Social Security No.

Address Street No. Apt. No. | City | State | Zip | Home Phone | Occupation

(3) EMPLOYER OF INSURED 投保僱主資料

Name | Phone

Address Street No. | City | State | Zip

(4) INSURANCE COMPANY OF INSURED 保險公司資料

Name of Insurance Company | Address

Phone No. | Group / Policy No. | Membership / ID No. | Medicaid Seq. No.

(5) OFFICE USE ONLY Insurance Check Date :_____

Effective date: _____ Benefit Renewal: _____ Individual / Family Max Coverage: _____ (Used: _____)

Last Dental Visit: _____ Deductible: _____ Apply to □ P: ____% □ B: ____% □ M: ____% □ O: ____%

Frequency Limitation: R / C : _____ / _____ M / Y ; BW : _____ / _____ M / Y ; FMX : _____ / _____ M / Y

Denture : _____ / _____ M / Y ; Crown : _____ / _____ M / Y ; (Last FMX : _____)

Implant / D6010: □Yes □No TMJ/OE / D9952: □Yes □No O Guard / D9940: □Yes □No Splint / D7880: □Yes □No

Waiting Period: Filling: _____ Denture: _____ RCT: _____ Crown & Bridge: _____

Insurance Follow Up: □ Not Eligible □ Eligible Informed Patient Date: _____ Appt on: _____ Update: □ Computer □ Patient folder

MEDICAL HISTORY 病歷

	Yes	No
1. Are you now seeing a physician? 你現在有因為身體不適看醫生嗎？	____	____
2. Are you now taking medications, drugs, pills, etc? 你現在有吃藥嗎？	____	____
3. Do you have any allergy? 你有任何敏感嗎？	____	____
4. Do you have heart disease? 你有心臟病嗎？	____	____
5. Do you have rheumatic fever? 你有類風濕心臟病嗎？	____	____
6. Do you have high blood pressure? 你有高血壓嗎？	____	____
7. Do you have lungs problem? 你有肺病嗎？	____	____
8. Do you have shortness of breath, swollen ankle? 你有氣喘、腳腫嗎？	____	____
9. Do you have bleeding disorder? 你有血誘病或流血不止的問題嗎？	____	____
10. Do you have endocrine problems such as diabetic? 你有內分泌腺問題如糖尿病嗎？	____	____
11. Do you have kidney or bladder problem? 你有膀胱或腎臟的問題嗎？	____	____
12. Did you stay in a hospital before? 你有住過醫院嗎？	____	____
13. Did you receive any blood-transfusion before? 你有接受過輸血嗎？	____	____
14. Did you receive radiation or chemotherapy before? 你有接受過藥療或電療嗎？	____	____
15. Did you receive steroid therapy before? 你有接受過類固脖治療嗎？	____	____
16. Are you healthy? 你是否健康？	____	____
17. Do you drink and / or smoke? 你有喝酒或抽煙嗎？	____	____
18. Are you pregnant? 你是否懷孕？	____	____
19. Is there any thing about your medical history that I have not mentioned in this questionnaire? 有其他病歷嗎？	____	____

Blood Pressure : _____ Pulse : _____ / min Weight : _____ lb

This medical history is not an exhaustive list, for me to give you the best service, I need your information. Please report all medical conditions to me even though they seem not important to you.
以上病歷可能並不完整，讓我可以給您最好的服務，請將所有病歷告訴我。

Patient's / Parents' Signature : _____
病人 / 家長簽名

DENTAL HISTORY (1) 病歷

	Yes	No
1. Why are you here today? 你今天到診目的是 : _____		
2. Are you in pain now? 你現在有痛嗎？	____	____
3. Do your gums bleed when you brush your teeth? 刷牙有流血嗎？	____	____
4. Do you have sores in your mouth frequently? 常常有口腔潰瀾嗎？	____	____
5. Do you habitually grind or clench your teeth? 有沒有咬牙的習慣？	____	____
6. Do you have jaw joint pain before? 牙關節有痛嗎？	____	____
7. Do you have braces before? 牙齒有沒有接受過矯正？	____	____
8. Do you have dry mouth all the time? 時常口乾嗎？	____	____
9. Do you have teeth sensitivity to cold or heat? 牙齒有對冷熱敏感嗎？	____	____
10. Do you have spaces between your teeth? 有過大的牙縫嗎？	____	____
11. Do you know what is plaque? 有聽過甚麼是牙垢、垢膜嗎？	____	____
12. Do you know what is calculus / tartar? 有聽過甚麼是牙石嗎？	____	____
13. Are you unhappy with the color or appearance of your teeth? 對牙齒的顏色、形狀是否不滿意？	____	____
14. Are you afraid of seeing a dentist? 看牙醫怕嗎？	____	____
15. When did you last see a dentist? What was done? 上一次看牙是在何時？做過甚麼？ _____		

16. Did you have the following dental work performed?
    你有接受過以下治療嗎？

☐ Full Mouth X-ray 全口 X 光	☐ Denture 活動假牙	☐ Crown 固定牙冠
☐ Root Canal Therapy 根管治療	☐ Bridge 固定牙橋	☐ Filling 補牙

17. How is your dental health?
    你的口腔衛生如何？

☐ Poor 很差 ☐ Fair 普通 ☐ Good 很好 ☐ Excellent 十分好

DENTAL HISTORY (2) 病歷

1. How often do you brush your teeth? 刷牙次數

   0 1 2 3 4 5 times per day / week / month

2. How often do you floss your teeth? 用牙線次數

   0 1 2 3 4 5 times per day / week / month

3. How often do you use mouth wash? 漱口次數

   0 1 2 3 4 5 times per day / week / month

4. Do you use any other dental health aid? If yes, please specify:
   有用其他口腔清潔用品嗎？請註明。

   _____

****

Consent :

I hereby give consent to any member of the staff of the Medical Dental Service to perform any treatment or operation on myself, my spouse, my son, my daughter as they deem necessary. This includes the giving of any local or general anesthetic as may be indicated. I also give permission to take photographs for clinical purposed.
本人同意接受治療，包括麻醉及拍攝有關的相片。

Patient's / Parents' Signature : _____ Date : _____
病人 / 家長簽名 日期

****

Signature on File :

I hereby authorize that as long as Dr. John Wai-lun Sung keeps this document of file, he may use it to represent my consent in filling for insurance payment of any dental procedures he has performed for myself or my dependents.

Payment of the group insurance benefits otherwise payable to me will be made directly to Dr. John Wai-lun Sung.

I authorize the release of any information relating to these claims.

Signature of Insured Person : _____ Date : _____
受保人簽名 日期

PRIVACY NOTICE CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your right under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, or health care operations. We are not required to agree to his restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has Notice of Privacy Practices and that patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name – Patient or Representative

_____ _____/_____/_____
Signature Date

Relationship to patient
(If other than patient): _____

Witness: _____
Printed Name – Practice Representative

_____ _____/_____/_____
Signature Date