DALLAS ORTHOPEDIC & SHOULDER INSTITUTE

JEFF ZHAO, D.O.
2704 N. Galloway Ave., Ste. 101
Mesquite, TX 75150
PHN 214.256.3778 FAX 214.256.3770

Patient Information 初診病患基本資料卡

姓名 **Name:**_____ 出生日期 **Date of Birth** ___/___/____（日/月/年）

性別**Sex:** 男**M** 女**F** 已婚 **Married** 喪偶**Widowed** 單身**Single** 離婚**Divorced**
社會安全號碼**SS#** _____

地址 **Address:**_____ 市 **City** _____州 **State:**_____ 郵遞區號 **Zip:** _____

行動手機 **Cell Phone:** _____住家電話 **Home Phone:** _____

工作電話 **Work Phone:** _____

電子信箱 **Email Address:**_____@_____

(Please Complete if Patient is a Minor) 病患未滿 18 歲請法定監護人填寫以下

法定監護人姓名 **Legal Guardian Name:** _____與病患關係 **Relationship:** _____

地址（如果和上列不同）**Address (if different from above):**_____

市 **City**_____州 **State:** _____郵遞區號 **Zip:** _____

緊急連絡人 Emergency Contact

姓名 **Name:** _____關係 **Relationship:** _____
住家電話 **Home Phone:**_____手機行動 **Cell Phone:** _____

Primary Insurance Information 首選 保險資料

保險公司名稱 **Insurance Company:** _____
投保人姓名 **Policy Holder Name:**_____
出生日期 **Policy Holder Date of Birth:** ____/____/____ 社安號 **SS# :**_____
保單號 **ID/Policy #:**_____保單類 **Group#:**_____ 請參查保險卡）
理賠地址 **Claim Adress:**_____

Secondary Insurance Information 次選 保險資料

保險公司名稱 **Insurance Company:**_____投保人姓名 **Policy Holder** _____
出生日期 **Policy Holder Date of Birth:**____/____/____ 社安號 **SS# :**_____
保單號 **ID/Policy #:**_____保單類 **Group#:**_____（請參查保險卡）
理賠地址 **Claim Address:** _____

簽名 Patient Signature:_____ **日期 Date:** ____/_____/_____

(Parent or Legal Guardian if Minor 如未滿 18 歲請法定監護人簽名）
病患姓名 Patient Name: _____ 日期 **Date:** _____

What is the reason for your visit? 請問今日就診原因?

_____

_____

What are your current symptoms (example: pain, numbness, etc…)? 簡訴目前的症狀如:疼痛、麻木等、?_____

_____

病史或醫療記錄 Past Medical History

Please list all medical diagnosis and conditions:請列出所有的醫療診斷和病症記錄_____

_____

_____

_____

手術記錄病史 Past Surgical History

Have you had any prior surgeries? ___ Yes ___ No 之前有無任何手術？有/無

Please list all surgeries you have had with the surgeon name:如果有請寫出名稱或簡訴_____

_____

_____

個人生活資料 Social History

What is your occupation? 職業是什麼_____Retired/Disabled 退休/殘疾人士

Who lives at home with you? 一起居住的家庭成員_____

Do you smoke?抽煙嗎? ___ Yes 有 ___ No 無

Do you use illicit drugs?使用違禁藥嗎? ___ Yes 有 ___ No 無

Do you drink Alcohol? 有酗酒（過度飲用酒精性飲料嗎?）___ Yes 有 ___ No 無

如果有，請簡訴多久需要飲酒一次 If yes how Frequent?_____

家族史 **Family History**

Relation to Patient 與患者 關係	Are they living? 存/歿	If deceased what was the cause death? 如果過世何原因?	If deceased at what age did they pass? 過世時年紀?
Mother 母親			
Father 父親			
Sibling 兄弟子妹			

藥局資料 ***Pharmacy Information***

藥局名稱 **Pharmacy Name:** _____電話 **Phone Number:**_____

地點 **Location:** _____城市 **City** _____

Please list any allergies to medications: 請列出所有藥物過敏藥名_____

_____

Please list all your current medications, including strength and how often you take them:

請列出目前服用的所有藥品名稱：包括用量和多久的服用史

Medication 藥名	**Strength 劑量**	**Number of Times a Day 次數/天**
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	

Have you suffered from any of the following medical conditions? 你有沒有以下病症的記錄

最近有沒有發寒或發燒	有	無	腹部疼痛	有	無
最近有沒有瘀青	有	無	腎臟問題	有	無
最近有沒有皮疹	有	無	尿道感染	有	無
有沒有關節炎	有	無	血尿	有	無
有沒有視覺障礙	有	無	紅斑性狼瘡， 硬皮症等	有	無
頸部疼痛	有	無	背痛	有	無
哮喘 ，氣喘	有	無	關節疼痛	有	無
支氣管炎	有	無	癲癇	有	無
肺氣腫	有	無	中風	有	無
肺炎	有	無	昏眩	有	無
氣短 胸悶	有	無	大小便失禁	有	無
肺結核	有	無	暈厥	有	無
高血壓	有	無	四肢無力	有	無
胸痛	有	無	精神方面問題	有	無
心臟病	有	無	焦慮	有	無
循環系統問題	有	無	憂鬱 壓力 沮喪	有	無
心悸	有	無	糖尿病	有	無
四肢腫脹	有	無	甲狀腺問題	有	無
膽囊問題	有	無	癌症	有	無
消化性潰瘍疾病	有	無	肝炎	有	無
血便	有	無	風濕病	有	無
持續黑便症狀	有	無	性功能障礙	有	無
便秘	有	無	不正常出血	有	無
拉肚子，下痢	有	無	血塊，血栓	有	無

In order to provide you with the best quality of care, we keep open communication with your PRIMARY CARE PHYSICIAN.

為了提供您最佳品質的醫療照顧，我們會和你保險所指定之全科家庭醫師連絡

Physician Name: 醫師姓名_____

Office Phone Number:診所電話 _____

How did you hear about us? (Please circle one or multiple if applicable)

你是如何得知我們的資訊（請勾選或複選）

1. Physician 醫師

   Name of the referring physician 推薦醫師姓名：_____

   Phone 電話: _____

2. Hospital/Facility (Please circle one)醫院/醫療機構（請選一）
   - Dallas Regional Medical Center
   - Texas Regional Medical Center at Sunnyvale
   - Pine Creek Medical Center
   - Texas Health Resource
   - Other (Please specify)其他, 請說明_____
3. Word of Mouth by 通過口碑介紹 朋友推薦
   _____ (So we can properly thank him/her!)
4. Brookshire Pharmacy bags Brookshire 藥袋
5. Your insurance 你的保險
6. Internet search 網路搜尋
   a. Google
   b. ZocDoc
   c. Healow.com
   d. Mesquite Star
   e. Healthgrade
   f. WFAA.com (Channel 8)
   g. Other_____
7. Chinese Newspaper/Yellow pages 中文報紙/中文黃頁電話本
8. Television 電視
   a. Good Morning, Texas 早安德州
   b. Other (Please specify) _____其他請說明
9. Other (please specify) _____其他請說明

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

Please read and initial each paragraph 請仔細閱讀並縮寫簽名每個一格內

_____ Dallas Orthopedic and Shoulder Institute and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice. 達拉斯骨科研究所和相關的醫生們在致力於保護您的健康資訊之隱私性。我們提供您有關我們的隱私慣例通知的影本。您不被要求閱讀此通知，但是如草簽，表示您確認收到本通知書。

_____I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Dallas Orthopedic and Shoulder Institute for any services furnished to my by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

我請求授權聯邦醫療保險和其他保險的福利付款以我的名義到達拉斯矯形外科，做為我的醫療保健任何服務相關聯的費用。本人授權我的任何醫療的資訊可傳到衛生保健籌資管理和其代理人或保險公司，確定這些好處或福利金為持有人之所需相關服務的資訊。

_____I appoint Dallas Orthopedic and Shoulder Institute to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

我授權指定達拉斯骨科作為我授權代表，在我有關於拒絕服務或拒絕付款的保險計畫請求上訴。

_____Unless I request to the contrary in writing, I will accept appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of this practice

除非我書面請求與此反對，我會接受掛號約定提醒透過我家裡的電話答錄系統和/或掛號提醒卡郵寄的並了解此法規政策

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions. 為了保持我們在盡可能最合理划算的水準收費，我們對患者有關的財務責任的理解是很重要的。我們希望這份摘要將有助於幫助 了解。我們鼓勵你與我們討論，提出問題。

We understand that your health coverage is provided through 我們瞭解你的健康保險提供以下

- If you have out-of-network benefits, we will happily file claims on your behalf.
  如果你有了保險系統的 “out-of-network“好處，我們樂意地將以您的名義索賠
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office, Dallas Orthopedic and Shoulder Institute.
  你必須支付任何共同支付和適用的扣除數額，除非我們的辦公室、達拉斯矯形外科有其他安排。
- The remainder of your bill will be sent to your health plan for direct payment to our office
  帳單的其餘部分將被發送到你的健康計畫，直接支付給我們的辦公室
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
  如果你承保保險在 45 天內不支付給我們提出之醫療費用，我們將會要求你付款。
- If, by mistake, your health plan remits payment to you, you agree to send it to us along with all paperwork sent to you at the time.
  如果搞錯了，你的健康計畫給你匯款支付，您同意把它寄給我們，以及所有的文件 部份。
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
  你將繼續負責數額和不受你的保險計畫的任何服務。
- Your health plan may refuse payment of a claim for some of the following reasons:
  你的健康計畫可能拒絕支付索賠的一些原因如下：
  1) This is a pre-existing illness that is not covered by your plan
     這是一種預先存在的疾病，不包含在保險計畫
  2) You have not met your full calendar year deductible
     還沒有到你的完整的年度扣除日
  3) The type of medical service required is not covered by your plan
     醫療服務所需的類型不包含在你保險
  4) The health plan was not in effect at the time of service
     健康計畫對此項的服務當時不生效
  5) You have other insurance which must be filed first
     你有其他保險必須先提交

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be excluded in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full. 請您理解醫療服務的財政責任在於你與你的健康計畫。雖然我們很高興能你為你的醫療保險服務，我們並非負責教導，可能會被排除在你的計畫中的任何限制。如果你的健康計畫否認這種說法對任何這些或其他原因，我們的辦公室不能負責這項條例草案。它是你的責任，作為病人要全額支付的被保險拒絕的數額

As a part of convenience service to you, our office provides DMEs (durable medical equipment), such as arm slings, shoulder braces, and etc to those in need of them. Our specialized staff will fit appropriately for you for the correct DME. In cases of imperfect fit, we will be happy to refit you at no additional cost as long as you notify us ASAP when you start noticing problems. You may also return UNUSED item in its ORIGINAL package within **7** days of receipt to receive full refund. 為提供給您便利服務，我們的辦公室提供標準的 （耐用醫療設備），如手臂吊索、 肩背帶等給需要的病患。我們專門的工作人員將為正確的選料材質適合你。在不完美的吻合度的情況下，只要您通知我們儘快且很樂意改裝並不增加額外費用，當你開始注意到的問題請快速告知。你也可能收到全額退款，附收據 7 日內其原包裝返回並且未使用的專案。

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. However, we reserve the right to refuse service if you have an outstanding account balance that no payment has been arranged. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you. 我們的主要使命是為您提供優質，成本有效的醫療護理。我們一起不斷變化和調適最佳的方式，衛生保健資助和交付。然而，我們保留權利拒絕服務，如果您有沒有付款或是有優秀的帳戶餘額。但在此基礎上，我們很重視您作為一個病人，我們的首要任務是為您提供最好的服務。為圓滿此任務，我們很高興為你服務。

I have completed this form with accurate information and have read and understand my obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier. 我已經了解並閱讀此表單並理解我的義務。我必須完全負責提供正確的保險資訊、 計費資訊和支付任何服務不覆蓋或批准我保險理賠的部份。

_____ _____

Signature of Patient 患者 簽名 Date 日期

No Show Policy

A “no show” is someone who misses an appointment without canceling 24 hours (1 working day) in advance. No-Shows inconvenience those individuals who need access to medical care in a timely manner. 失約,是一個人掛號卻沒有赴約就診，而沒有提前在 **24** 小時之內取消掛號（**1** 個工作日）。使其他那些需要及時地獲得醫療服務的人造成不便。

A failure to present at the time of a scheduled appointment will be recorded in the patient’s chart as a “no show”. 未能在預約的時間就診將作為**"no show"**記錄在病人的病歷表 **An administrative fee of $25.00 may be billed to the patients account. The patient will be sent a letter alerting to the fact that they have failed to show up and did not cancel within the 24-hour time period in advance.** 病人會收到一封信，提醒他們未能如期就診和沒有提前的 **24** 小時取消掛號的事實，並收取**$25.00** 行政費用。

A copy of the letter will be placed in the patient’s file. Three “no-shows” may result in the temporary suspension of services. 信的副本將放置在病人的檔案內。三個**"**失約記錄**"**可能會導致暫停服務的拒絕往來戶。

In order to reinstate services, the patient may be required to pay all fees associated with the no show policy. 為了恢復服務，病人可能會被要求支付所有費用與相關 “失約”法規政策

Patient Name:患者 姓名 _____

Responsible Party/Guardian: 監護人_____

Signature: 簽名 _____

Date: 日期 _____

PATIENT PORTAL ACTIVATION

Our office now has the ability to communicate with patients through an electronic Patient Portal. This portal will allow you to request appointments, view lab results, view current scheduled appointments, request medication refills, request referrals to specialists, complete medical questionnaires, view summaries of your recent visits and more. In order to activate this functionality for you personally, we MUST have an active e-mail address associated with your account. 我們的辦公室已與患者通過電子網路和病人溝通互動。這個入口網站將允許您預約掛號，查看實驗檢測報告結果，查看當前安排的約診，處方藥物索取，要求轉介至專科醫生，完成醫療問卷，您最近的訪問和更多的視圖等摘要。為了你能自己啟動此功能，我們必須有一個您的電子郵件地址。請填寫電子郵箱地址。

Please list your e-mail address here:_____ @ _____

_____*DO NOT WANT TO PARTICIPATE （不想參與）*

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

授權獲得處方的歷史記錄

I authorize this office to have access to my prescription drug history. I understand this authorization allows this office to obtain my prescription history electronically from retail pharmacies. 本人授權這個辦公室可訪問我處方藥物的歷史。我明白這項授權允許這間辦公室以獲得我的處方歷史記錄透過電子方式從藥局。

Patient's Signature:簽名 _____ Date : 日期_____

AUTHORIZATION TO OBTAIN MEDICAL RECORD

授權獲得醫療記錄

I authorize this office to have access to my medical records from other healthcare providers pertaining and assisting my medical care by providers at Dallas Orthopedic & Shoulder Institute. 本人授權該辦公室有權獲得我的醫療記錄其他衛生保健提供者有關，並協助我在達拉斯骨科 & 肩研究所提供的醫療服務

Patient Signature: 簽名_____ Date: _日期_____

AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION
授權披露醫療/財務資訊

Federal privacy guidelines, HIPAA, prevent this office from disclosing protected health (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility. 聯邦隱私準則，HIPAA，妨礙這個辦公室披露受保護的健康 （PHI） 向病人以外的人。通過簽署本表格，允許我們指定的個人，關於這一設施醫療和財務記錄和交流

I, the undersigned, hereby authorize Dallas Orthopedic & Shoulder Institute to disclose PHI from my medical or financial record to the following person/people: 本人的簽字，特此授權達拉斯骨科 & 肩研究所向以下的人披露我的醫療或財務記錄：

1. Name:姓名 _____ Relationship:關係 _____
   Phone:電話 _____

Type of Information: 資訊型態(Circle One) 選一 Medical 醫藥 Financial 財務 Both 二者

2. Name: 姓名_____ Relationship:關係 _____
   Phone: 電話_____

Type of Information: 資訊型態(Circle One) 選一 Medical醫藥 Financial財務 Both二者

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY
其他人可能會列出的，如果有必要

This authorization is given freely with the understanding that: 理解並自由作出這項授權

1. I may revoke this authorization in writing at any time, but not retroactively.
   我可能會撤銷這項授權中： 在任何時間，但不是具有追溯力。
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.
   我已授權該設施、 其雇員、 官員和醫生特此免除任何法律義務或責任因我資訊披露

_____ _____

Patient's (or Guardian's) Signature 簽名 Date 日期