Oral Pathology,
Oral Medicine and
Orofacial Pain

Lan Su, DMD, PhD

Welcome

PATIENT INFORMATION (Confidential)

Name_____ Date_____

Address_____SSN#_____

City_____State_____Zip_____

Phone ( )_____D.O.B_____Sex_____Age_____

Single__ Married__ Divorced__ Widowed__ Separated__

Business Phone( )_____ Employer_____

Business Address_____

RESPONSIBLE PARTY

Name of Person Responsible for this account_____

Relation to Patient_____Date of Birth_____

Driver's License#_____SSN#_____

Employer & address_____

STATEMENT

I consent to have clinical services provided by Dr. Lan Su, and understand that I will be responsible for payment of all services.

_____ _____ _____

Signature of Patient or Responsible Party Print Name Date

INSURANCE AUTHORIZATION – SIGNATURE ON FILE

Lan Su, DMD, PhD

31332 Via Colinas, #109
Westlake Village, CA 91361

Tel 818 865 1039
Fax 818 865 8375

1310 West Stewart Dr. #202
Orange, CA 92868

Tel 714 856 3349
Fax 818 865 8375

I, the undersigned certify that I (or my dependent) have insurance coverage with_____, group #_____

Additional insurance_____, group #_____

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company. I authorize the use of this signature on all insurance submissions.

_____ _____

Date Signature of Patient or Insured

_____ _____

Date Witnessed By

The signature on file (SOF) is valid from this date. A photocopy of this authorization may act as an original.

Oral Pathology, Oral Medicine and Orofacial Pain Lan Su DMD. PhD

HEALTH QUESTIONNAIRE

Name:		D.O.B.:
Physicians Name:	Phone: ( )	Date of Last Visit:
Address:	City:	State & Zip:
Dentist's Name:	Phone: ( )	Date of Last Visit:
Address:	City:	State & Zip:

Major mouth problem or reason for coming:_____

1. Have you had unexplained gain or loss of weight (past 6 months)? If so how much?	Yes	No
2. Do you smoke or use tobacco? If Yes, how much?	Yes	No
3. Do you drink alcoholic beverages? If Yes, how much?	Yes	No
4. Have you ever been treated for cancer?	Yes	No
5. Have you ever had radiation treatment?	Yes	No
6. Do you have a poor appetite?	Yes	No
7. Do you sleep poorly or use medications to sleep?	Yes	No
8. Do you feel that you are currently more tired than usual?	Yes	No
9. Do you have many body aches and pains?	Yes	No
10. Do you have night sweats or recurring fever?	Yes	No
11. Have you ever used intravenous drugs?	Yes	No
12. Have you used cocaine or "crack" within the past 6 months?	Yes	No
13. Do you actively engage in high risk behavior for infectious diseases? (e.g., AIDS, hepatitis)	Yes	No
14. Please describe your general health.		

Do you have or have ever had:

HEAD AND NECK

15. Recurrent headaches?	Yes	No
16. Glaucoma/ eye disease?	Yes	No
17. Recurrent earaches/ hearing problems?	Yes	No
18. Chronic sinusitis/ post-nasal discharge?	Yes	No
19. Recent difficulty swallowing?	Yes	No
20. Persistent sore throat and hoarseness?	Yes	No
21. Swollen neck glands?	Yes	No
22. Recurrent neck ache or neck pain?	Yes	No
23. Injury to head, neck, jaw, teeth?	Yes	No

DENTAL

24. Chronic face pain/ jaw pain?	Yes	No
25. Clicking/ Popping of jaw?	Yes	No
26. Difficulty opening or closing jaw?	Yes	No
27. Unable to chew food well?	Yes	No
28. Blisters/ Sores on lips or mouth?	Yes	No
29. Unpleasant taste/ bad breath?	Yes	No
30. Burning tongue/ lips?	Yes	No
31. Swelling/ lumps in mouth?	Yes	No
32. Bleeding or infected gums?	Yes	No
33. Loose teeth?	Yes	No
34. Pain when chewing or opening mouth?	Yes	No
35. Bothersome catching of food between the teeth?	Yes	No
36. Recent toothache/ sensitivity?	Yes	No
37. Uncomfortable bite?	Yes	No
38. Recent need to chew on one side?	Yes	No
39. Clenching/ Grinding?	Yes	No
40. Your bite adjusted?	Yes	No
41. Bite appliance (TMJ Splint)	Yes	No
42. Gum treatment or surgery?	Yes	No
43. Orthodontic treatment (braces)	Yes	No

Do you have or have ever had:

NEUROMUSCULAR SYSTEM

44. Fainting spells or loss of consciousness?	Yes	No
45. Seizures?	Yes	No
46. Numbness, tingling, or paralysis?	Yes	No
47. Muscle weakness/ multiple sclerosis?	Yes	No
48. Recurrent backaches?	Yes	No
49. Problem/ walking, balance, dizziness?	Yes	No
50. Persistent stiffness or painful joints?	Yes	No
51. Artificial bone or joint implants?	Yes	No
52. Recent or unusual headaches?	Yes	No

RESPIRATORY

53. Breathing problems?	Yes	No
54. Asthma or Emphysema?	Yes	No
55. Tuberculosis or a persistent cough?	Yes	No
56. Coughed up blood?	Yes	No
57. Pneumonia?	Yes	No

CARDIOVASCULAR

58. High blood pressure?	Yes	No
59. Awaken with breathing difficulty?	Yes	No
60. Difficulty breathing when lying down?	Yes	No
61. Swollen ankles?	Yes	No
62. Irregular or rapid heart beats?	Yes	No
63. Chest Pain due to physical exertion?	Yes	No
64. Chest pain when upset?	Yes	No
65. Rheumatic heart disease or fever?	Yes	No
66. Congenital heart disease/ heart murmur?	Yes	No
67. Prolapsed heart valve?	Yes	No
68. Cardiac or vascular surgery?	Yes	No
69. Heart attack and /or angina?	Yes	No
70. Other heart problems?	Yes	No
71. A stroke?	Yes	No

Do you have or have you ever had:

GASTROINTESTINAL/ GENTITO-URINARY

72. Persistent diarrhea/ odd colored stools?	Yes	No
73. Colitis or ulcers?	Yes	No
74. Unexplained vomiting/ frequent nausea?	Yes	No
75. Alcoholic liver disease?	Yes	No
76. Hepatitis or other liver disease?	Yes	No
77. Jaundice (yellow skin or eyes)?	Yes	No
78. Awaken more than twice a night to urinate?	Yes	No
79. Kidney disease/ renal dialysis?	Yes	No
80. A kidney transplant?	Yes	No
81. Any urinary infection?	Yes	No
82. Syphilis?	Yes	No
83. Gonorrhea?	Yes	No
84. Any other sexually transmitted disease?	Yes	No

Do you have or have you ever had:

HEMA/ ENDO/ IMMUNE

90. Bruise easily/ bleed excessively after a cut?	Yes	No
91. A blood transfusion?	Yes	No
92. Anemia or denied permission to give blood?	Yes	No
93. Leukemia (cancer of the blood)?	Yes	No
94. Diabetes or been frequently thirsty?	Yes	No
95. Thyroid or adrenal gland disease?	Yes	No
96. AIDS or ARC (AIDS Related Complex)?	Yes	No
97. Positive blood test for HIV antibodies?	Yes	No
98. Skin blotches or rash?	Yes	No`
99. Rheumatoid arthritis?	Yes	No
100. Chronic itching?	Yes	No

Do you have or have you ever had:

ALLERGIES or reactions to:

85. Penicillin?	Yes	No
86. Sulfa drugs?	Yes	No
87. Dental anesthetics?	Yes	No
88. Metal (rings/earrings)?	Yes	No
89. Other (specify)?	Yes	No

WOMEN ONLY

101. Do you menstruate regularly?	Yes	No
102. Do you flow heavily?	Yes	No
103. Are you now pregnant?	Yes	No
104. If so, please give due date?		
105. Are you in or have you passed through menopause (change of life)?	Yes	No
106. Are you taking hormones?	Yes	No
107. Are you taking birth control?	Yes	No

FAMILY HISTORY: Has anyone in your family (Grandparent, parent, sibling, child) ever had:

108. Bleeding disorder?	Yes	No	112. Cancer?	Yes	No
109. Heart Disease?	Yes	No	113. Tuberculosis?	Yes	No
110. Mental/ emotional disorders?	Yes	No	114. Diabetes?	Yes	No
111. Any genetic diseases disorders/ illness(please specify)?					

Behavioral:

116. Are there some aspects of the appearance of your teeth and jaw that need to be changed?	Yes	No
117. Do you often feel depressed or moody?	Yes	No
118. Do you often feel anxious or nervous?	Yes	No
119. Have you ever had psychiatric or psychological counseling?	Yes	No
120. Did you ever avoid a dental appointment because you were frightened?	Yes	No
121. Do you ever feel uncomfortable asking questions of doctors?	Yes	No

List all prescription and non-prescription drugs (including aspirin) taken within the past 6- months:

Name	Dosage	Name	Dosage	Name	Dosage
1.		**3.**		**5.**	
2.		**4.**		**6.**	

Please list any hospitalizations and emergency room visits (include dates and reasons)

1.	4.
2.	5.
3.	6.

122. Have you been dissatisfied with previous dental or medical treatment? If yes, please describe:

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my doctor at my next appointment.

Patient Signature:_____Date:_____Guardian:_____Date:_____

FINANCIAL POLICIES

Our patients understand that in order to deliver optimum specialty service, we must maintain our office on sound business principles. Therefore, we inform our patients of our financial policies at the very beginning of our relationship to avoid any misunderstandings.

Payment is due at the time services are rendered unless arrangements are made before you see the doctor.

Our financial policies are as follows:

1. Financial arrangements are not made based on insurance reimbursement. However, we are pleased to bill applicable insurance carriers (excluding Medicare, Medi-Cal, HMOs) for you and have them reimburse you directly. Please let us know if you are a beneficiary of Medicare, and a beneficiary of Medicare requires to sign an additional contract.

2. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

3. If a comprehensive treatment is involved, it is presented to all patients before any work begins. We consult with our patients so that there is full understanding of the procedures by which treatment is rendered. The costs and the time required to perform the services are also discussed. If at any time it is necessary to change the treatment plan and additional charges or credits are applicable, this is explained to the patient and agreed to before the services are rendered.

4. In order to operate our business efficiently, a 30-day outstanding balance will have a monthly finance charge of 0.5% or a minimum $5.00 administration fee for each additional statement. An outstanding balance over 60 days will be forwarded to our collection agency for further actions, although this is never our wish to do so.

Please let us know if you have any questions or concerns.

I have read the Financial Policies. I understand and agree to these Policies.

X_____ Date_____
Signature of responsible party/patient

X_____ Date_____
Witnessed by

Acknowledgement of Receipt of Notice of Privacy Practices

Lan Su, DMD, PhD

Diplomate of American Board of Oral and Maxillofacial Pathology
Fellow of American Academy of Oral Medicine

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1310 West Steward Dr. Suite 202
Orange, CA 92868

Tel (714) 856 3349
Fax (818) 865-8375

Patient Name: _____
Patient Phone Number: _____
Patient Address: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Lan Su DMD, PhD.

_____ _____
Signature Date

If signing as personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____