REGISTRATION RECORDS
歡迎蒞臨

Date 日期 _____

Patient's Name 姓名 _____ Last 姓 First 名 MI 別名 Date of Birth 出生日期 _____

Single 單身 ☐ Married 已婚 ☐ Divorced 離婚 ☐ Widowed 喪偶 ☐ Sex F/M 性別 Home Phone 電話 _____

Name of Spouse 配偶姓名 _____ Parent's Name (if child) 父母姓名(如果是小孩) _____

Address 住址 _____ Number & Street City State Zip Code

Patient Employed by 病人受僱於 _____ Occupation 職位 _____

Business Phone No. ( ) 辦公室電話 _____ Address 地址 _____

Soc. Sec. No. 社會福利編號 _____ Driver's License No. 駕照號碼 _____

If you have Dental Insurance, Name of Company 如果你有牙醫保險，保險公司名字 _____

Insured Person's Name 投保者名字 _____ Group No. 編號 _____

Soc. Sec. No. (If different from the patient) 社會福利編號(如果不是病人自己的) _____

Whom may we thank for referring you 哪位介紹你來 _____

Do you have any family member attending in our office? 有沒有其他家人曾在本診所治療牙齒? _____

E-mail 電子信箱地址: _____

Cell / Phone 手機電話: ( ) _____

Day 白天號碼: ( ) _____

Night 晚上號碼: ( ) _____

GENERAL HEALTH HISTORY

Date of Last Physical Exam 上次體格檢查日期 _____ Name of Your Physician 醫生名字 _____

Do you have or have you had any of the following. Please indicate with a check mark.
如果你有，或曾經有過下列的病況請打勾

_____ Any heart problem 任何心臟問題
_____ High blood pressure 高血壓
_____ Low blood pressure 低血壓
_____ Circulatory problem 血液循環問題
_____ Nervous System problems 神經系統問題
_____ Radiation treatment 輻射線照射
_____ Excessive bleeding 流血過多
_____ Others 其他

_____ Anemia 貧血
_____ Arthritis 關節炎
_____ Asthma 氣喘
_____ Diabetes 糖尿病
_____ Epilepsy 癲痫
_____ Thyroid Disease 甲狀腺炎
_____ Jaundice/Liver Disease 黃疸 / 肝病
_____ None of above 以上皆無

_____ Hepatitis 肝炎
_____ Herpes 疱疹
_____ Ulcer 潰瘍
_____ Rheumatic Fever 風濕熱病
_____ Tuberculosis 結核病
_____ Aids 愛滋症
_____ Hay Fever/Sinusitis 花粉熱 / 竇炎

Are you sensitive or allergic to any of the following medicine?
你是否對下列藥物敏感?

_____ Penicillin 青黴素
_____ Codeine 合成古柯鹼

_____ Aspirin 阿斯匹靈
_____ Anethesia 麻醉劑

_____ Sleeping Pills 安眠藥
Others 其他 _____

Has there been any change in your general health, within the past year? 去年之間你的健康情況有無任何變化? Yes 是 ☐ No 否 ☐

Do you consider yourself a nervous person? 你認為你是個容易緊張的人嗎? Yes 是 ☐ No 否 ☐

Have you ever required a blood transfusion? 你接受過輸血嗎? Yes 是 ☐ No 否 ☐

Please list all medications you have taken during the last three months: _____
請列下最近三個月內你服用過的所有藥物。
WOMEN - Are you pregnant? Yes ☐ No ☐
女士　妳懷孕嗎？　是　否

DENTAL HISTORY

Date of your last dental visit _____ Date of last dental X-Ray _____
上次牙科檢查日期　上次牙科X光檢查日期
Any complication with extraction? Yes ☐ No ☐ If yes, Please discribe: _____
拔牙有過任何併發症嗎？　是　否　如果有，請敘述
Do you have or have you ever had any of the following?
你有沒有下列的症狀？

MOUTH 口腔

	Yes 是	No 否
Bleeding, sore gums 牙齦流血或疼痛	☐	☐
Unpleasant taste/bad breath 口臭	☐	☐
Burning tongue/lips 舌或唇有熱刺感	☐	☐
Frequent blisters, lips/mouth 唇口粘膜經常有水泡	☐	☐
Ortho treatments (braces) 牙齒矯正	☐	☐
Biting cheeks/lips 經常咬到面頰或嘴唇	☐	☐
Swelling/lumps in mouth 口內有腫脹	☐	☐
Clicking/popping jaw 下顎關節有雜音	☐	☐

TEETH 牙齒

	Yes 是	No 否
Loose teeth 牙齒鬆動	☐	☐
Sensitive to hot 對熱敏感	☐	☐
Sensitive to cold 對冷敏感	☐	☐
Sensitive to sweets 對甜食敏感	☐	☐
Sensitive to biting 咀嚼時牙齒敏感	☐	☐
Food impaction 食物塞牙縫	☐	☐
Clenching/grinding 有磨牙、咬牙的習慣	☐	☐
difficulty opening or closing jaw 有開、閉口的困難	☐	☐

To the best of my knowledge, all of the above answers are true and correct. If I ever have any change in my medication, I will inform thedentist at the next appointment.
上述的開題回答，都是依我所能記憶的據實答案。如果我服用的藥物有變化，我會在下次看牙時通知我的醫生。

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.
我將同意醫生依我的病況需要做X光檢查、取模型、照相、及其他輔助診斷的檢查，我亦同意醫生依診斷做牙齒治療、處方等，我也了解麻醉、治療等均有其危險性，治療所需的費用，我將同意於治療完後給付，或者由保險付給醫師。

Signature of Patient _____ Date _____
Parent or Guardian
病人或父母(監護人)簽名　日期

對乳膠手套過敏: Allergy to Latex ? Yes___No___
用減肥藥Phen-Fen: Use Phen-Fen ? Yes___No___
您的醫師電話: Physician's phone # _____
緊急時聯絡人名及電話: Person to contact in case of emergency _____ and phone # _____
治療骨質疏鬆症藥物如: Medication of osteoporosis such as _____