Shi·MI·zu
GENERAL & AESTHETIC DENTISTRY

ACQUAINTANCE FORM & HEALTH HISTORY

Patient Information

氏名(ローマ字)
Name: _____

氏名(漢字)
Name: _____

性別(男・女)
Gender (M/F): _____

生年月日
Birth Date: _____

結婚の有無
Marital Status (M/S): _____

ソーシャルセキュリティー番号
Social Security #: _____

運転免許証番号
Driver's License #: _____

住所
Home Address: _____

市
City: _____

州
State: _____

郵便番号
Zip: _____

電話番号
Home Phone: _____

携帯番号
Cell Phone: _____

電子メール
E-mail: _____

勤務先名
Name of employer: _____

勤務先住所
Work Address: _____

市
City: _____

州
State: _____

郵便番号
Zip: _____

勤務先電話番号
Work Phone: _____

一番ご都合の良い予約確認方法
How would you like to receive confirmation of your appointment?

電子メール
E-mail ____

テキスト
Text ____

電話
Phone ____

当院へのご紹介者または その他の紹介機関
Name of Person or Other Source Referring You to Our Practice:

ご友人・知人
Friend (Name:)

医師名
Doctor (Name:)

インターネット
Internet ____

ダイレクトメール
Direct-mail ____

広告名
Advertisement( )

その他
JBAH Directory____

Others( )

Insurance Information

保険会社の名前 (歯科用)
Name of Insurance Company: _____

保険加入者の氏名
Name of Insured: _____

患者の保険加入者との関係
Patient's Relationship to Insured:

自身
Self

配偶者
Spouse

子
Child

その他
Other

保険加入者の会社名
Insured's Employer Name: _____

保険加入者のソーシャルセキュリティー番号
Insured's Social Security #: _____

保険加入者勤務先住所
Employer's Address: _____

保険加入者の生年月日
Insured's Date of Birth: _____

保険加入者の勤務先電話番号
Insured's Employer Tel #: _____

Dental History & Other Information

最後に歯科受診をされた日はいつですか
Date of Last Dental Visit:

どちらで
Where?:

			Yes/はい	No/いいえ
01.	Do you have pain in or near your ears?	現在、耳あるいはその付近に痛みがありますか。	_____	_____
02.	Do you have any unhealed injuries or inflammation in mouth?	現在、お口の中に傷や炎症がありますか。	_____	_____
03.	Does any part of your mouth hurt when clenched?	現在、噛みしめると痛むところがありますか。	_____	_____
04.	Do you have any sore spots or tenderness in the mouth?	現在、お口の中に痛いところ、あるいは触ると痛いところがありますか。	_____	_____
05.	Any experience with dental anesthesia in the past?	歯科麻酔 (注射) を受けたことがありますか。	_____	_____
06.	Any allergic reactions to dental anesthesia?	歯科の麻酔にアレルギーがありますか (注射針もふくむ)	_____	_____
07.	Any difficult extractions in the past?	歯を抜くのが困難であったことがありますか。	_____	_____
08.	Prolonged bleeding following extractions in the past?	歯を抜いたとき、これまでに血が止まりにくかったりしたことがありますか。	_____	_____

			Yes/はい	No/いいえ
09.	Are you under any medical treatment now?	現在、内科的治療を受けておられますか。	_____	_____
10.	Have you had any major operations? If so what?	これまでに大きな手術を受けたことがありますか。	_____	_____
	When? いつごろ? _____	What? 手術名は? _____		
11.	Have you had any serious head injuries?	これまでに頭に大きなケガをしたことがありますか。	_____	_____
12.	Have you had any adverse reactions to any drugs?	薬物に対するアレルギーがありますか。	_____	_____
13.	Have you ever had any of the following?	これまで医師から以下に示す疾患を指摘されたことがありますか。	_____	_____
	Heart ailment/Heart attack?	心臓病 心臓発作	_____	_____
	Stroke?	脳卒中	_____	_____
	Pacemaker?	ペースメーカー	_____	_____
	High blood pressure?	高血圧	_____	_____
	Respiratory disease?	呼吸器系疾患	_____	_____
	Asthma?	ぜんそく	_____	_____
	Sinus Problems?	上顎洞炎	_____	_____
	Tuberculosis?	結核	_____	_____
	Diabetes?	糖尿病	_____	_____
	Rheumatic fever?	リューマチ熱	_____	_____
	Rheumatism, arthritis or artificial Joints?	リューマチ又は関節炎	_____	_____
	Tumors or cancers?	腫瘍	_____	_____
	Any blood disease?	血液の疾患	_____	_____
	Anemia?	貧血	_____	_____
	Any liver disease, hepatitis, Jaundice?	肝臓病、肝炎、黄疸	_____	_____
	Any kidney disease?	腎臓病	_____	_____
	Any stomach or intestinal disease?	胃腸病(消化器系疾患)	_____	_____
	Any venereal disease?	性病	_____	_____
	Epilepsy?	てんかん	_____	_____
	Glaucoma?	緑内障	_____	_____
	Excessive Bleeding?	血がとまりにくい	_____	_____
	HIV/AIDS?	エイズ	_____	_____
	Mental Disorders?	精神障害	_____	_____
	Nervous Disorders?	不安障害	_____	_____
	Chronic cough?	慢性の咳	_____	_____
	Codeine allergy?	コデインの アレルギー	_____	_____
	Penicillin/Amoxicillin allergy?	ペニシリン系の抗生物質アレルギー	_____	_____
14.	Do you have night sweats or any weight loss?	体重の減少を伴うような寝汗をかくことが ありますか?	_____	_____
15.	Are you on a diet at this time?	現在ダイエット中ですか	_____	_____
16.	Are you taking drugs or medications?	現在、服用している薬がありますか。	_____	_____
17.	Drugs or Medications you are presently taking?	現在服用中の薬剤名	_____	_____
18.	Are you allergic to any known materials (Ex. latex)?	何か特定の物に対するアレルギーがありますか。ラテックスなど	_____	_____
19.	Have any wounds healed slowly or any complications?	傷の治りが遅かったり、化膿したりしやすい方ですか。	_____	_____
20.	Do you have a history of fainting?	これまでに気を失ったことがありますか。	_____	_____
21.	Have you had any X-ray treatment for tumors?	これまでに放射線治療を受けたことがありますか。(腫瘍などの治療等で)	_____	_____
22.	(For Women) Are you pregnant?	女性の方へ　現在妊娠中でいらっしゃいますか。予定日 _____	_____	_____
23.	Are you in a habit of smoking?	現在、喫煙の習慣がありますか。	_____	_____
24.	Are you in general good health at this time?	現在、健康体でいらっしゃいますか。	_____	_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

リセット　　プリント