Personal Information 个人信息:

Name 姓名: D M Y

Mr.先生 Mrs.太太 Ms.女士 _____ Date of Birth: _____/_____/_____

Last name 姓 First name 名 出生日期 日 月 年

Home Address: _____

居住地址 Street 街道 City 城市 Postal Code 邮编

Home # ( )_____ Business # ( )_____ Cell # ( )_____ Other # ( )_____

住家电话 商业电话 行动电话 其他

Name of spouse, parent, or nearest relative: _____ Phone # ( )_____

配偶，父母或至亲姓名 电话

If patient is a **minor**, who is legally responsible: _____ Phone # ( )_____

如果未成年者就医，法律上的负责人 电话

Employer 雇主: _____ Phone 电话 #: ( )_____ Occupation 职业: _____

Referring Dentist 转诊牙医: _____ Family Physician 家庭医生: _____

Insurance Information (if applicable):

Do you have dental insurance? 你有牙科保险吗？ 如果是，请填写:

Primary insurance company: _____

Group/policy #: _____

ID/Cert #: _____

Div #: _____

Employer: _____

Secondary insurance company: _____

Group/policy #: _____

ID/Cert #: _____

Div #: _____

Employer: _____

Spouse/partner name: _____

Date of birth: D_____/M_____/Y_____

If primary coverage through spouse/partner, then please fill in:

Their name: _____ Date of birth: D_____/M_____/Y_____

Dual Insurance Coverage for Children – requires both parent's birthdates:

Mother's date of birth: D_____/M_____/Y_____ Father's date of birth: D_____/M_____/Y_____

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

I understand that I am responsible for all the costs of dental treatment.

Permission for Root Canal Treatment and Local Anaesthetic:

Upon being informed of all treatment options, I the undersigned, being the patient or if minor, the parent or guardian, consent to the performing of whatever procedure may be determined necessary by the Doctor. I authorize and request the administration of such drugs and/or anaesthetics as may be deemed advisable by the Doctor. I also understand that upon completion of root canal therapy in this office, I will be referred to my dentist for a permanent restoration, such as, an amalgam restoration, onlay, or crown.

Patient/Parent/Guardian signature: _____ Date: D_____/M_____/Y_____

Medical History 病史:

Your care card number 健康卡号: _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? 你有过任何严重的疾病，手术，或在过去 5 年住院吗? Yes 有_____ No 没有_____ If yes, what was the illness/reason? 如果有，原因是什么？_____

Are you currently taking medication? 你现在服用任何药物吗? Yes 有_____ No 没有_____

If yes, what are you taking? 如果是，哪些药物?_____

Does your medical history include any of the following? 您的病史包括以下任疾病吗? :

Yes 有____ No 没有____ 1. Rheumatic or congenital (inborn) heart disease 风湿性心脏病，先天性心脏病

Yes 有____ No 没有____ 2. Heart murmur, damage, or artificial heart valves 心脏杂音，损伤或人工心脏瓣膜

If yes, do you require pre-medicate? 如果有，你需要使用预防药物吗: Yes 有___ No 没有___

Yes 有____ No 没有____ 3. Cardiovascular disease (heart trouble, stroke) 心血管疾病 (心脏病，中风)

Yes 有____ No 没有____ 4. High or low blood pressure 高或低血压

If yes, do you take medication? 如果有，你服药吗: Yes 有___ No 没有___

Yes 有____ No 没有____ 5. Do you have a cardiac pacemaker? 你有心脏起搏器吗

Yes 有____ No 没有____ 6. Asthma, emphysema, or tuberculosis 哮喘，肺气肿或结核病

Yes 有____ No 没有____ 7. Fainting, seizures, epilepsy, or neurological disorders 晕厥，癫痫或其他神经疾病

Yes 有____ No 没有____ 8. Diabetes 糖尿病

Yes 有____ No 没有____ 9. Hepatitis, jaundice, or other liver disease 肝炎，黄疸或其他肝脏疾病

Yes 有____ No 没有____ 10. Sexually transmitted disease 性传播疾病

Yes 有____ No 没有____ 11. AIDS or HIV infection 艾滋病或 HIV 感染

Yes 有____ No 没有____ 12. Thyroid problems 甲状腺问题

Yes 有____ No 没有____ 13. Stomach ulcer 胃溃疡

Yes 有____ No 没有____ 14. Kidney trouble 肾脏病

Yes 有____ No 没有____ 15. Problems with mental health 心理健康问题

Yes 有____ No 没有____ 16. Cancer or tumour 癌症或肿瘤

Yes 有____ No 没有____ 17. Problems of the immune system 免疫系统的问题

Yes 有____ No 没有____ 18. Blood disorders, such as anaemia 血液疾病，如贫血

Yes 有____ No 没有____ 19. Abnormal bleeding 异常出血

Yes 有____ No 没有____ 20. Have you had joint replacement surgery? 有关节置换手术吗?（膝，髋等）

If yes, do you require pre-medicate? 如果有，你需要使用预防药物吗? Yes 有___ No 没有___

Yes 有____ No 没有____ 21. Do you have any other illness not mentioned above? 你有没有其他疾病?

Are you allergic or had any reaction to: 你对这些药物有过敏吗?

Yes 有____ No 没有____ Penicillin 青霉素等抗生素

Yes 有____ No 没有____ Sulfa drugs 磺胺药物

Yes 有____ No 没有____ Aspirin, acetaminophen (Tylenol), or Ibuprofen (Advil, Motrin) 阿司匹林或其他止痛药

Yes 有____ No 没有____ Codeine or other narcotics 可待因或其他麻醉剂

Yes 有____ No 没有____ Barbiturates, sedatives, or sleeping pills 巴比妥酸盐，镇静剂或安眠药

Yes 有____ No 没有____ Local anaesthetics (novocaine) 局部麻醉药

Yes 有____ No 没有____ Any other drugs or medications 任何其他药物

For women patients 对女性患者:

Are you pregnant? 你怀孕了吗? Yes 有_____ No 没有_____ Are you nursing? 你是喂母乳吗? Yes 有_____ No 没有_____

In regards to your own health and our staff's health, please sign below to certify that you have answered each question to the best of your knowledge: 事关您自己的健康和我们工作人员的健康，请在下面签名，以证明您已尽力回答每个问题:

Patient/Parent/Guardian signature 签名: _____ Date 日期: D_____/M_____/Y_____