



Registration Form: 信息登记表

Answers to the following questions are for our records only and will be considered confidential.

What is your main dental concern? 您主要关心的牙齿问题是什么? _____

Personal Information: 个人信息

(Dr./Mr./Mrs./Miss) Last Name 姓氏: _____ First Name 名字: _____

Birth Date (yyyy/mm/dd) 出生日期(年/月/日) _____ Sex 性别: Male 男 Female 女

Address 地址: _____ City 城市: _____ Postal Code 邮政编码: _____

Contact number (M/H/W) 联系电话(手机/家庭/工作): _____

Email address 电子邮箱: _____

Emergency contact 紧急联系人: _____ Contact number 联系电话: _____

Family doctor 家庭医生: _____ Contact number 联系电话: _____

Care Card number (MSP) 医疗卡号码: _____

When was the last visit to a dentist? 最近一次看牙医的时间? _____

Are you covered by a dental plan? 你有牙医保险吗?

No Yes (please provide details to the front desk 请把资料提供给前台)

Medical History: 病史

Have you ever had any of the following? (Please check) 请问您是否得过以下疾病? (请打勾)

- | | | |
|--|---|--|
| <input type="checkbox"/> Hepatitis 肝炎 | <input type="checkbox"/> Stroke 中风 | <input type="checkbox"/> Blood/Bleeding disorder 出血性疾病 |
| <input type="checkbox"/> Diabetes 糖尿病 | <input type="checkbox"/> HIV Positive 艾滋病 | <input type="checkbox"/> Sinus Trouble 鼻窦炎 |
| <input type="checkbox"/> Rheumatic fever 风湿性热 | <input type="checkbox"/> Tuberculosis/Lung Disease 肺结核/肺病 | <input type="checkbox"/> Cancer 癌症. Type 类型: _____ |
| <input type="checkbox"/> Heart Murmur 心杂音 | <input type="checkbox"/> Kidney Disease 肾病 | <input type="checkbox"/> Allergies 过敏. Type 类型: _____ |
| <input type="checkbox"/> Epilepsy 癫痫 | <input type="checkbox"/> Osteoporosis 骨质疏松 | |
| <input type="checkbox"/> High Blood pressure 高血压 | | |

Had Radiotherapy/Chemotherapy before? 有做过放疗/化疗吗? When? 什么时候? _____

Are you taking any medicine? (Name/Type) 您是否正在服药? (名字/类型) _____

Ever had any serious illness which required major operation? 您是否曾经有过严重疾病需要手术?

For Woman 女士专用

Are you pregnant? 你是否在怀孕? No 没有 Yes. How many months? 有, 几个月? _____

Do you smoke? 您是否抽烟? No 没有 Yes 有

For Children 小孩 Name of Parent/Guardian 家长或监护人名字: _____

Office Policy

Payment is due when the service is rendered, unless financial arrangements are made in advance. 2 days advance notice is required if you are unable to keep appointments.

Signature 签名: _____ Date 日期: _____