

Chart #: _____
FOR OFFICE USE ONLY

Patient Information/患者情報

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender/性別: _____ Age/年齢 _____
Social Security #/ソーシャルセキュリティ番号: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Address: _____
Street Apartment #
City State Zip Code
渡米された日: _____ 帰国予定日: _____

Health Information/健康状態

Date of Last Dental Visit in the U.S./最後にアメリカで歯科にかかれたのはいつですか?: _____
Reason for this visit/本日来院された理由は?: _____

Have you ever had any of the following? Please check those that apply: 当てはまるものにチェックをして下さい。

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV/エイズ | <input type="checkbox"/> Heart Murmur
心肺雑音 | <input type="checkbox"/> Pregnancy/妊娠
Due date/出産予定日 | <input type="checkbox"/> Thyroid problems
甲状腺障害 |
| <input type="checkbox"/> Allergies/アレルギー | <input type="checkbox"/> Hepatitis/肝炎 | <input type="checkbox"/> Radiation Treatment
放射線療法 | <input type="checkbox"/> Tuberculosis/結核 |
| <input type="checkbox"/> Anemia/貧血 | <input type="checkbox"/> High Blood Pressure
高血圧 | <input type="checkbox"/> Respiratory Problems
呼吸器障害 | <input type="checkbox"/> Tumors/腫瘍 |
| <input type="checkbox"/> Artificial Joints 人
工関節 Date: _____ | <input type="checkbox"/> Kidney Disease
腎臓病 | <input type="checkbox"/> Rheumatic Fever
リュウマチ熱 | <input type="checkbox"/> Ulcers/潰瘍 |
| <input type="checkbox"/> Asthma/喘息 | <input type="checkbox"/> Liver Disease/肝臓病 | <input type="checkbox"/> Rheumatism
リュウマチ | <input type="checkbox"/> Drug Allergy
薬品アレルギー |
| <input type="checkbox"/> Blood Disease/血液病 | <input type="checkbox"/> Mental Disorders
精神病 | <input type="checkbox"/> Sinus Problems/鼻炎 | OTHER: その他 |
| <input type="checkbox"/> Cancer/ガン | <input type="checkbox"/> Nervous Disorders
不安症 | <input type="checkbox"/> Stroke/大発作 | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes/糖尿病 | <input type="checkbox"/> Pacemaker
ペースメーカー | | |
| <input type="checkbox"/> Epilepsy/てんかん | | | |
| <input type="checkbox"/> Glaucoma/緑内障 | | | |
| <input type="checkbox"/> Heart Disease/心臓病 | | | |

• Have you ever had any complications following dental treatment? Yes No/歯科治療中にショック症状を起こした事がありますか? If yes, please explain: _____

• Are you now under the care of a physician? Yes No/現在医者にかかっていますか?
If yes, please explain: _____

• Name of Physician: 主治医名 _____ Phone: _____

• Are you taking any medication? Yes No/現在服用している薬がありますか?
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail./記入したものに偽りはありません。

Signature of patient, parent or guardian 患者(保護者)の署名 _____ Date: _____ 日付

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
どなたの紹介ですか?
 Dental Office Yellow Pages Newspaper School Work Other _____

Spouse or Responsible Party Information/医療費負担者氏名

The following is for: the patient's spouse/配偶者 the person responsible for payment/本人

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information/勤務先

The following is for: the patient/患者 the person responsible for payment/医療費負担者

Employer Name/会社名: _____ Occupation/職業: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information/保険情報

Primary/保険加入主について記入して下さい。

Name of Insured: _____ Is insured a patient? Yes No
保険加入主 氏名 Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
保険加入主 生年月日
Insured's Address: _____
保険加入主 住所 Street City State Zip Code
Insured's Employer Name: _____
保険加入主 勤務先
Address: _____
Street City State Zip Code
Patient's relationship to insured/続柄: Self Spouse Child Other _____
Insurance Plan Name and Address 保険会社名: _____

Secondary/他の保険にも加入されてる場合のみ記入して下さい。

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Consent for Treatment/治療同意書

I hereby authorize dr. or designated staff to take x-ray ,study models,photographs, and other diagnostic aids deemed appropriate by dr. to make a thorough Diagnosis dental needs. レントゲン、歯型、写真などを使用して歯の診断を行うことを許可します。

Upon such diagnosis, I authorize dr. to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to Provide proper care. 医師と今後の治療プランについて相互理解に至ったうえでの歯の治療を行うことを了承します。

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. 局所麻酔、鎮痛剤などの薬を必要とされる際の使用を許可します。

I understand that I can ask for a complete recital of any possible complications.

麻酔を使用する際の副作用などを理解したうえで治療することに同意します。

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, Unless other arrangements have been made. The treatment estimate is not a guarantee. I agree to be responsible for all changes not covered by Insurance company. 治療当日に自己負担見積額での支払いに同意します。また保険会社の治療費見積は保証された金額ではありません。

実際の治療費と見積書に差額が生じた際は 差額分を支払うことに同意します。

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian 患者(保護者)の署名 _____ Date: _____ Relationship to Patient: _____
日付 続柄