CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Date_____

PATIENT NAME (Last, First, Middle): _____ TITLE: _____
名前（Last name を先に書いてください）
ADDRESS: _____CITY_____ST_____ZIP_____
住所
HOME PHONE: ( ) _____ WORK: ( ) _____ CELL: ( ) _____
BIRTH DATE _____/_____/_____ S.S.# _____/_____/_____ How did you hear about us?_____
誕生日 ソーシャルシキュリティ この歯医者をどのようにしてしりましたか
SEX (PLEASE CIRCLE): M F MARITAL STATUS (circle one): Single Married Divorced Widowed
性 結婚状況
EMAIL: _____
MEDICAL ALERTS: _____
医療警告
Date of Last Physical Exam: _____/_____/_____ Date of Last Dental Exam: _____/_____/_____
最後に医者の診察を受けた日 最後に歯医者に行った日

1. Are you now or have you recently been under a physician's care? _____ Yes _____ No
現在あるいは、最近医者の治療をうけていますか。
Reason: _____

2. Have you ever been a patient in a hospital or had any serious illness?
入院したり、重病にかかったりしましたか。
Explain: _____

***ALLERGIES* アレルギー**

3. Are you allergic to or do you suffer ill effects from any of the following?
アレルギー性体質、あるいは、以下の物にひどいアレルギー反応を示したことがありますか。

YES	NO		YES	NO		YES	NO	
____	____	Penicillin ペニシリン	____	____	Codeine コデイン			Dental Anesthesia 表面麻酔
____	____	Erythromycin エリスロマイシン	____	____	Latex ゴム手袋	____	____	Bleach 漂白剤

Please list any other allergies you may have: _____
上記の他に、アレルギー症状を起こすものを書いてください。

4. Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
____	____	Arthritis 関節炎	____	____	Hepatitis or Jaundice 肝炎、黄疸	____	____	Bleeding Problems 出血の問題
____	____	Rheumatic Fever リューマチ熱	____	____	Liver Disease 肝臓の病気	____	____	Fainting Tendency 気絶
____	____	Heart Trouble 心臓の問題	____	____	Cancer or Tumor 癌、腫瘍	____	____	Epilepsy 癲癇
____	____	Heart Murmur 心音の雑音	____	____	Tuberculosis 結核	____	____	Thyroid Disease 甲状腺の病気
____	____	High/Low Blood Pressure (please circle one)	____	____	Diabetes 糖尿病		____	Glaucoma 緑内障
____	____	Chest Pain 肺の痛み	____	____	Kidney/Bladder Trouble 腎臓、膀胱の問題	___	____	Radiation Treatment 放射線治療_
____	____	Stroke 脳溢血	____	____	Anemia 貧血症	____	____	Psychiatric Disorders 精神病
____	____	Shortness of Breath 息切れ	____	____	Lung Disease 肺の病気	____	____	HIV or AIDS エイズ
____	____	Asthma or Hay Fever 喘息、花粉症	____	____	Venereal Disease性病	____	____	Prosthetic Joint Replacement 義足
____	____	Sinus Trouble 副鼻腔炎	____	____	Blood Disease 血液の病気	____	____	Blood Transfusion 輸血
____	____	Severe Head Injury 頭の重傷	____	____	Emphysema 肺気腫	____	____	Ulcers 潰瘍

5. Check any of the following that you are taking or have taken:過去あるいは、現在使用しているもの

YES	NO		YES	NO		YES	NO	
____	____	Steroids ステロイド	____	____	Blood Thinners 血液比重を薄くする。	____	____	Sedatives 鎮静税
____	____	Osteoporosis medications 骨粗鬆の薬						

6. Are you taking any other medication? ____ YES ____ NO Please list: _____
他に薬を飲んでいますか

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7. Have you ever been asked to **pre-medicate** before dental appointments for the following conditions? (Circle all that apply):

Cyanotic Congenital Heart Disease Cardiac Transplant Artificial Heart Valves History of Infective Endocarditis
Prosthetic Joint Replacement Other:_____

Women Only: Are you pregnant? ____ Yes ____ No If yes: How many months? _____ Are you breast feeding? _____

***PLEASE NOTE:** If you are taking any kind of birth control pills, shots or implants, hormone therapy, etc., please indicate these medications in question #6.もし、避妊薬、注射、インプラント、ホルモン治療などをうけていれば、＃６に明記してください。

FINANCIALLY RESPONSIBLE PARTY FOR PATIENT

<u>This form must be filled out completely</u>. NOTE: if the person financially responsible for your bill is someone other than a guardian or spouse, we will need to call and verify authorization from this person or business prior to any treatment being performed.

If you have dental insurance, please fill out section I. If you do not have dental insurance, please fill out section II. 歯科保険情報

Section I.

GUARANTOR INSURED'S NAME (This is also the person responsible for payment of any co-pays, co-insurance, and/or balances after insurance pays).
主要被保険者の情報

(Last, First, Middle): _____ TITLE: _____

ADDRESS: _____CITY_____ST_____ZIP_____

HOME PHONE: ( ) _____ WORK: ( ) _____ CELL: ( ) _____

S.S.# _____/_____/_____ D.O.B. _____/_____/_____ RELATIONSHIP TO PATIENT:_____
患者との関係

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____
雇用主
EMPLOYER'S ADDRESS: _____

DENTAL INSURANCE COMPANY: _____
歯科保険会社の名前
(please provide your insurance card)

Section II.（歯科保険のない人のみ）

PATIENT HAS <u>NO</u> INSURANCE. THE PERSON/BUSINESS BELOW IS RESPONSIBLE FOR PAYMENT.

(Last, First, Middle): _____ TITLE: _____

ADDRESS: _____CITY_____ST_____ZIP_____

HOME PHONE: ( ) _____ WORK: ( ) _____ CELL: ( ) _____

S.S.# _____/_____/_____ D.O.B. _____/_____/_____ RELATIONSHIP TO PATIENT:_____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____