WELCOME TO ROYA DENTAL

标*为必填项

LAST NAME 姓*	FIRST NAME 名*	MIDDLE NAME INITIAL	DATE OF BIRTH 出生年月日*	
ADDRESS 地址*	APT # 公寓号码*	CITY 城市*	MALE 男性*	FEMALE 女性*
PROVINCE 省份*	POSTAL CODE 邮编*	HOME TELEPHONE 家庭号码	MOBILE NUMBER 手机号码*	
OCCUPATION	BUSINESS TELEPHONE		EMAIL ADDRESS 邮箱	
PHYSICIAN NAME	PHYSICIAN ADDRESS		PHYSICIAN PHONE NUMBER	
DENTIST NAME	DENTIST ADDRESS		DENTIST PHONE NUMBER	

IN CASE OF EMERGENCY NOTIFY 紧急联系人

NAME 姓名	RELATIONSHIP 关系	PHONE NUMBER 电话号码

PRIMARY INSURANCE COMPANY

POLICY HOLDER	POLICY NUMBER	CERTIFICATE NUMBER

SECONDARY INSURANCE COMPANY DATE OF BIRTH

POLICY HOLDER	RELATIONSHIP	POLICY NUMBER	CERTIFICATE NUMBER

Your medical and dental health histories are essential for the determination and course of your treatment in our office. It is important that you complete this questionnaire accurately as it will become part of your office record. *Be assured that it will be held in strict confidence*.

MEDICAL HEALTH HISTORY 药物健康史*

A. **Please check if you have any of the following:** *(if yes to any of the following, please explain in space provided in section "**B**")*

- I AIDS/HIV Positive 艾滋病
- I Anxiety 焦虑
- I Arthritis(osteo/Rheumatoid) 关节炎
- I Artificial heart valves 人工心脏瓣膜
- I Artificial joints 人工关节
- I Asthma 哮喘
- I Back Problems 背部问题
- I Blood disease 血液病
- I Cancer Chemotherapy 肿瘤化疗
- I Circulation problems 血液循环问题
- I Cortisone treatments 可的松关节炎药物
- I Cough, persistent 持续性咳嗽
- I Diabetes 糖尿病
- I Dementia/Alzheimer's 阿尔兹海默症
- I Epilepsy 癫痫症
- I Facial plastic surgery 面部整形
- I Fainting 昏厥
- I Food allergies 食物过敏
- I Glaucoma 青光眼
- I Headaches, frequent 经常性头疼
- I Headaches, migraines 偏头痛
- I Hearing impairment 听力障碍
- I Heart murmur 心脏杂音
- I Heart problems 心脏问题

Describe 请在下方描述

_____

- I Hemophilia 血友病
- I Herpes 疱疹
- I Hepatitis A B C 甲乙丙型肝炎
- I High blood pressure 高血压
- I Jaw Pain 下巴疼痛
- I Kidney disease 肾病
- I Liver disease 肝病
- I Mitral valve prolapsed 二尖瓣脱落
- I Nervous problems 神经问题
- I Neurological problems 神经问题
- I Pacemaker 起搏器
- I Psychiatric care 精神病护理
- I Radiation 辐射
- I Respiratory/lung disease 呼吸/肺病
- I Rheumatic fever 风湿热
- I Seizure disorders 癫痫/发作性疾病
- I Shingles 带状疱疹
- I Shortness of breath 气促
- I Skin rash 皮疹
- I Sleep Apnea 睡眠窒息
- I Stroke 中风
- I Surgical implants 外科植入物
- I Swelling, feet/ankles 脚部肿胀
- I Thyroid problems 甲状腺问题
- I Tobacco use/smoking 抽烟
  How much_____
  How long_____
- I Tuberculosis 肺结核
- I Ulcers/colitis 溃疡
- I Other auto-immune diseases 其他自身免疫疾病_____

Known Allergies 过敏物:

- I Local anesthetic 局部麻醉
- I Aspirin 阿司匹林
- I Penicillin 青霉素/阿莫西林
- I Sulfa 硫胺药物
- I Iodine 碘
- I latex 乳胶
- I Codeine 可待因
- I Tetracycline 四环素
- I Other 其他_____

B. **ADDITIONAL MEDICAL/ VITAMINS/ SUPPLEMENTS INFORMATION** 其他药物信息**:**

Female patients only 女性病人填写

- Are you pregnant? If yes, when is due date? _____
  请问您正在怀孕吗？
- Are you taking birth control pills? _____
  请您正在服用避孕药
- Are you taking hormone replacement? _____
  请问您正在进行激素替代吗？
- Are you nursing/breastfeeding_____
  请问您正在哺乳期吗？

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined this below. Our office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- To communicate with other treating healthcare providers including specialists and general dentists who are the referring dentist and/or peripheral dentist
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims for third party adjudication and payment
- To permit potential purchaser, practice brokers or advisors to evaluate and audit the dental practice in the possibility of a sale
- To deliver your charts and records to the dentist's insurance company to enable the insurance company to assess liability and quantify damages if any
- To communicate with and provide information to dental laboratories
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist our office to comply with all regulatory requirements
- To comply generally with the law

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor or hygienist at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs (x-rays) or other diagnostic measures appropriate for a thorough evaluation as well as the release of all pertinent information to my dental history (including x-rays) to any dentist or physician involved in my treatment and to my dental insurance company, where applicable. I agree that Dr. Li Ying Liu can collect, use and disclose personal information about the undersigned as set out above in the information about your offices' privacy policies.

Signature of patient, or parent if a minor: _____ Date_____

Reviewed by: _____ Date_____