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ー番号:* _____ 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:_____ E-mail Address:_____

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ら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。

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

• 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/現在医者にかかられていますか？
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. 記入したものに偽りはありません。

_____ Date: _____
Signature of patient, parent or guardian 患者（保護者）の署名 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 doctor or designated staff to take x-ray, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis for dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. 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。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. I understand that I can ask for a complete recital of any possible complications. 局部麻酔、鎮痛剤などの薬を必要とされる際の使用を許可します。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 charges not covered by Insurance company. 保険会社の治療費見積額は保証された金額ではありません。実際の自己負担額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 the content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian 患者（保護者）の署名 日付 続柄