# Get Acquainted Questionnaire

*Welcome to our office!*

We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information will be held in strict confidence. Thank you for joining our family of patients.

----------CONFIDENTIAL PATIENT INFORMATION----------

## Patient Registration Form / 病人登记表

Patient Name 病者姓名 Last 名 _____ First 姓 _____

DOB 生日_____ Age 年龄 _____ Sex 性别 _____

Social Security # 社会保障号码 _____ Phone number 电话号码_____

E-mail 电子邮件_____

Address 地址 _____ Apt # _____

City 城市 _____ State 州 _____ Zip 邮政编码 _____

Parent's Name (If child) 父母的姓名 (若为儿童) _____

Chief Complaint 主要投诉_____

_____

Name of Financially Responsible Party 财务责任方姓名 _____

Occupation 職業 _____

How Long Employed at This Job? 在这个职位上工作了多久 _____

Are You A Member of Any Union? **您是否是工会成**员？☐ Yes 是 ☐ No 否

(We will bill your insurance directly as a courtesy to you; if you are ineligible for insurance benefits when services are rendered, you will be responsible for any charges incurred.)

(出于对您的礼貌，我们将直接向您开具保险单；如果**您在接受服**务时不符合保险福利的资格，**您将**负责由此产生的任何费用. )

SO WE MAY BILL YOUR INSURANCE DIRECTLY, PLEASE SIGN 因此，我们可以直接向您开具保险单，请签字:

**Authorization / 授权声明** _____

## CONSENT TO FINANCIAL RESPONSIBILITY

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE CHARGES SHOWN ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION. I HEREBY ACCEPT THE DENTAL TREATMENT PLAN AND AUTHORIZE DENTAL CARE AND RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

我本人特此授权直接向上述指定牙医支付本应由我领取的团体保险金，但不得超过上述列明的费用。我理解我对本授权未涵盖的任何费用负有经济责任。我在此接受牙科治疗计划，**并授**权牙科护理和发布与本索赔相关的任何信息。

**Signature of Patient or Guardian / 病人或监护人签名**: _____

**Date / 日期**: _____

**Medical History 医**疗病史 (If patient is a minor, parent/guardian must answer the following questions pertaining to the patient's health)

1. Have you been under the care of a medical doctor during the past two years? / 在过去**两年中**，**您是否接受**过**医生的治**疗？
   ☐ Yes 是 ☐ No 否
   If yes, for what reason? /如果是，原因是 _____
   Doctor's Name **医生姓名**: _____ Phone 电话: _____
2. Have you been a patient in the hospital during the past five years? / 在过去五年中，**您是否住**过院 ☐ Yes 是 ☐ No 否
   For what reason? / 原因 _____

3. Please list all medications you have taken during the last three months / 请列出过去三**个月您服用的所有**药物

_____ Dosage / 剂量 _____

_____ Dosage / 剂量 _____

_____ Dosage / 剂量 _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? / **您是否知道自己**对任何药物或物质有过敏（或不良反应）？

If yes, please list / 如果是，请列出 _____

5. Please check if you have had or have any of the following / 请检查**您是否曾**经或目前有以下情**况**:

| **Yes 是** | **No 否** | | **Yes 是** | **No 否** | |
|---|---|---|---|---|---|
| ☐ | ☐ | HIV Positive / 艾滋病毒**阳**性 | ☐ | ☐ | Sinus Trouble / 鼻窦问题 |
| ☐ | ☐ | Glaucoma / **青光眼** | ☐ | ☐ | Asthma / 哮喘 |
| ☐ | ☐ | Blood Transfusion / 输血 | ☐ | ☐ | Neurological Disorder / 神经系统疾病 |
| ☐ | ☐ | Surgery / 手术 | ☐ | ☐ | Stroke / 中风 |
| ☐ | ☐ | Emphysema / 肺**气**肿 | ☐ | ☐ | Radiation Therapy / 放射治疗 |
| ☐ | ☐ | Hemophilia / 血友病 | ☐ | ☐ | Epilepsy or Seizures / 癫痫或抽**搐** |
| ☐ | ☐ | High Blood Pressure / 高血压 | ☐ | ☐ | Artificial Joint / 人工**关**节 |
| ☐ | ☐ | Tuberculosis / 结核病 | ☐ | ☐ | Chemotherapy / 化疗 |
| ☐ | ☐ | Sickle Cell Disease / 镰刀型细胞贫血 | ☐ | ☐ | Tumors / 肿瘤 |
| ☐ | ☐ | Heart Murmur / 心脏杂音 | ☐ | ☐ | Kidney Trouble / 肾脏问题 |
| ☐ | ☐ | Liver Disease / 肝病 | ☐ | ☐ | A.I.D.S / 艾滋病 |
| ☐ | ☐ | Rheumatic Fever / 风**湿**热 | ☐ | ☐ | Psychological Care / 心理治疗 |
| ☐ | ☐ | Hay Fever / 花粉症 | ☐ | ☐ | Thyroid Problems / 甲**状腺**问题 |
| ☐ | ☐ | Yellow Jaundice / **黄疸** | ☐ | ☐ | Taking Phen-Fen / 服用芬芬药物 |

## **Dental History** 牙科病史

1. Date of your last dental X-ray / 上次牙科 X 光检查日期 _____
2. Date of your last dental visit / 上次看牙日期? _____
3. Have you had any complications following dental treatment? **您在接受牙科治**疗后是否有任何**并**发症? ☐ Yes 是 ☐ No 否
4. Please check if you have had or have any of the following: / 请检查**您是否曾**经或目前有以下情**况**：

| **Yes 是** | **No 否** | | **Yes 是** | **No 否** | |
|---|---|---|---|---|---|
| ☐ | ☐ | Bleeding, sore gums / 牙龈出血、 | ☐ | ☐ | Sensitive to cold, hot, sweet / 对冷热**甜敏感** |
| ☐ | ☐ | Unpleasant taste/bad breath / 口臭/**异味** | ☐ | ☐ | Sensitive to biting / 咬东西时敏感 |
| ☐ | ☐ | Burning tongue/lips / 舌头/嘴唇灼热感 | ☐ | ☐ | Food impactions / 食物嵌塞 |
| ☐ | ☐ | Frequent blisters (lip/mouth) / 嘴唇/口腔常出现水泡 | ☐ | ☐ | Difficulty opening or closing jaw / 张嘴或闭嘴困难 |
| ☐ | ☐ | Swelling/lumps in mouth / 口腔肿胀或肿块 | ☐ | ☐ | Clenching/Grinding / 咬牙/磨牙 |
| ☐ | ☐ | Loose Teeth / 牙齿松动 | ☐ | ☐ | Clicking/popping jaw / 颌部咔哒**声**/弹**响** |

*To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will without fail, inform the doctor at my next appointment.*

**Signature of Patient or Guardian / 病人或监护人签名** _____

**Date / 日期** _____

**Doctor Signature / 医生**签名_____

DDS NOTES