Dentistry@360 Dr. Cecilia Wong & Associates 289-597-3601 info@dentistryat360.com

Patient Information 病人資料

Patient Name: _____ Date日期: _____
Last, 姓 First 名 MI (Preferred Name)

Gender 性別: ☐ Male 男 ☐ Female 女

Health Card # 健康卡號碼: _____ Birth Date 出生日期:(D日)_____(M月)_____(Y年)_____

Phone 電話(Home家): _____ (CELL手機): _____ (WORK工作): _____

Email 電郵:_____ Occupation 職業:_____

Address 地址: _____
Street 街道 Apartment # 室

_____
City 城市 Province 省 Postal Code 郵編

Health Information 健康資料

Date of Last Dental Visit 上次牙齒檢查日期: _____

Reason for this visit 這次求診目的:_____

Have you ever had any of the following? Please check those that apply: 請選項

☐ AIDS愛滋病
☐ Allergy:drug/latex/+ 過敏:藥物/乳膠/其他
_____
_____
☐ Angina心絞痛
☐ Arthritis關節炎
☐ Artificial Joints 人工關節
☐ Asthma哮喘
☐ Blood/Bleeding disorder出血性疾病
☐ Breastfeeding哺乳
☐ Cancer癌症
☐ Chemotherapy化療
☐ Diabetes糖尿病
☐ Drug/alcohol/cannabis use or dependency 濫用藥物/酒精/大麻
☐ Epilepsy癲癇
☐ Heart Attack 心臟病發作
☐ Heart Disease心臟病
☐ Heart Murmur心雜音
☐ Hepatitis肝炎
☐ High Blood Pressure 高血壓
☐ Infective Endocarditis 感染性心內膜炎
☐ Jaundice黃疸
☐ Kidney Disease腎病
☐ Liver Disease肝病
☐ Lung Disease肺病
☐ Mitral Valve Prolapse 二尖瓣脫垂
☐ Osteoporosis骨質疏鬆
☐ Pacemaker 心臟起搏器
☐ Pregnancy懷孕 Due date:_____
☐ Radiotherapy 放射治療
☐ Rheumatic Fever 風濕熱
☐ Shortness of Breath 呼吸急促
☐ Smoking吸煙
☐ Steroid Therapy 類固醇治療
☐ Stomach Ulcers 胃潰瘍
☐ Stroke, TIA中風
☐ Thyroid Disease 甲狀腺疾病
☐ Tuberculosis肺結核
☐ OTHER:

Please list all medications and non-prescription drugs 請列出現在服用的藥物(包括非處方藥物):

_____

- Have you ever had any complications following dental treatment 是否有過任何牙科治療後的併發症? ☐ Yes 有 ☐ No 沒有
  If yes, please explain 如有,請說明: _____
- Have you been admitted to a hospital or needed emergency care during the past 2 years 過去兩年有否因病住院或看急症?
  ☐ Yes 有 ☐ No 沒有
  If yes, please explain 如有,請說明: _____
- Are you now under the care of a physician 你目前有看醫生做治療嗎? ☐ Yes 有 ☐ No 沒有
  If yes, please explain 如有,請說明: _____
- Name of Family Doctor 家庭醫生:_____ Phone 電話: _____
- Name of Emergency Contact 緊急聯絡人: _____ Phone 電話: _____

_____ Date: 日期 _____
Signature of patient, parent or guardian 簽名(本人或監護人)

Referral Information 介紹資料

How did you hear about us 你是怎樣認識我們的？

_____

Consent for Services 同意書

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date 日期: _____

Signature of patient, parent or guardian 簽名(本人或監護人)

_____ Date 日期: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party 簽名(付款人） 與病人關係