

Patient Information Form**病人登记表**

Last Name (姓): _____ First Name (名): _____ M.I. (中间名) ____ Sex(性别): M(男) _ F(女) _

Date of Birth (出生月/日/年): ____ / ____ / ____ SSN (社会安全号): _____ / _____ / _____

Home Address (家庭住址): _____

City/Town (城市) _____ State (州) _____ Zip Code 邮编) _____

Home Phone # (家庭电话) _____ Cell # (手机) _____

Email (电子邮箱): _____ Occupation (职业) _____

Emergency Contact (紧急联系人名字): _____ Phone# (电话) _____

Primary Dental Insurance (主要牙科保险, 投保人信息)

Subscriber Last Name (姓): _____ First Name (名): _____ M.I. _____

Subscriber DOB(出生月/日/年) _____ Subscriber SSN (社会安全号) _____

Insurance Name (保险名字) _____ ID # (卡号) _____

Patient Relation to Subscriber (与投保人关系): Self (自己) ____ Spouse (配偶) ____ Child (孩子) ____

Subscriber's Home Address (if different than the above) (投保人家庭住址如果和病人不同)

Street (街) _____ City (城市) _____ State (州) _____ Zip Code (邮编) _____

Secondary Dental Insurance (leave blank if none) (第二份牙科保险, 没有不用填)

Subscriber Last Name (姓): _____ First Name (名): _____ M.I. _____

Subscriber DOB(出生月/日/年) _____ Subscriber SSN (社会安全号) _____

Insurance Name (保险名字) _____ ID # (卡号) _____

Patient Relation to Subscriber (与投保人关系): Self (自己) ____ Spouse (配偶) ____ Child (孩子) ____

Subscriber's Home Address (if different than the above) (投保人家庭住址如果和病人不同)

Street (街) _____ City (城市) _____ State (州) _____ Zip Code (邮编) _____

I hereby authorize payment of dental benefits billed to my insurance to Beacon Family Dental. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. I accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

(我同意保险公司付费给 Beacon Family Dental。我同意在治疗当时支付除去保险外我需要承担的费用。我同意承担治疗所需但保险不包括的费用。如果诊所没有加入我的保险公司网络，我同意承担超出保险的费用。)

A \$50 missed appointment / late cancellation fee will be charged to me if I fail to reschedule 24 hours prior to a confirmed appointment or cancel last minutes. After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice.

(确认预约后失约，或少于 24 小时内取消预约，需付费\$50。此类事情发生超过三次，我们将不再为您预约。当临时有空位时，我们可以临时电话联系您)

Signature of patient or guardian (病人或监护人签名) : _____

Date (日期) : _____

Disclosure:

We offer help with explanation of insurance benefit based on your insurance policy that we are able to check. But we can not guarantee insurance payment. If you need guaranteed insurance payment, please ask us to submit pre-estimate for you.

(我们根据能够查到的保险信息，帮助解释您的保险福利，但是我们不能保证保险公司最后付费情况。如果您需要确切的保险付费信息，请告诉我们帮您提交预估)。

Dental information (牙科信息)

Reason for today's visit (今天就诊原因): _____

Date of last dental visit (上次牙科就诊日期): _____ Treatment (所做治疗) _____

Date of last dental X-ray (上次拍 X 光片日期): _____

Please answer if you have the following problem. Please circle "Yes" or "No" for each.

(请回答是否有以下问题, 请在是或否上画圈)

Gums bleed when you brush or floss 刷牙或用牙线时牙龈出血	Y 是 N 否	Teeth sensitive to cold, hot, sweets or pressure 牙齿对冷, 热, 甜或压力敏感	Y 是 N 否
Food or floss catch between your teeth 食物或牙线塞牙	Y 是 N 否	Clicking, popping or discomfort in the jaw 下颌关节有声音或不适	Y 是 N 否
Grind your teeth 睡觉磨牙	Y 是 N 否	Sores or ulcers in your mouth 口腔溃疡或伤口	Y 是 N 否
Dental pain or discomfort 牙疼	Y 是 N 否	Serious injury to your head or mouth 头部或口腔严重创伤	Y 是 N 否

Medical information (医疗信息)

Are you now under the care of a physician? (你现在有家庭医生吗): Yes (是) No (否)

Physician Name (家庭医生姓名) _____ Phone (电话): _____

Address (地址): _____

Are you now taking any medication, drugs, or pills? (你在服用药物吗?) Yes (是) No (否)

If yes, please list medications (如果有, 请列出药物名字): _____

Are you allergic to or have you reacted badly to antibiotics, narcotics, local anesthetics, any other medications or substance (你对抗生素, 止痛药, 麻醉药, 其他任何药物或物质过敏吗)? Yes (是) No (否)

If yes, please list (如果有, 请列出): _____

Did you take or are you taking or scheduled to begin taking the medications for osteoporosis or Paget's disease?

(你服用过, 或正在服用, 或计划开始服用治疗骨质疏松或 Paget's 疾病的药物吗?)

Yes (是) No (否) Date (日期): _____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

(你做过关节置换手术吗? 包括胯关节, 膝关节, 肘关节, 指关节)

Yes (是) No (否) Date (日期): _____ Any complications?(有并发症吗): _____

Do you have artificial (prosthetic) heart valve or damaged heart valves?(你有人工瓣膜或瓣膜性疾病吗?)

Yes (是) No (否) Date (日期): _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

(你的家庭医生或之前的牙医有建议过你在牙科治疗之前服用抗生素吗?) Yes (是) No (否)

Do you use tobacco products? (你抽烟吗?) Yes (是) No (否)

Do you use controlled substances (drugs)? (你使用禁药或毒品吗?) Yes (是) No (否)

Do you drink alcoholic beverages? (你喝酒吗?) Yes (是) No (否)

How much alcohol did you drink in the last 24 hours? (过去的 24 小时你喝了多少?) _____

For Women Only (仅限于妇女):

Are you pregnant?(你怀孕了吗?) Yes 是 No 否 Estimate Delivery Date (预产期)_____

Are you nursing?(你在哺乳吗?) Yes 是 No 否

Are you taking birth control pills? (你在服用避孕药吗?) Yes 是 No 否

Indicate which of the following you have had, or have at present. Please circle "Yes" or "No" for each.

(请回答是否有以下疾病, 请在是或否上画圈)

Cardiovascular disease 冠心病	Y 是 N 否	Aspirin/Anticoagulant therapy 阿司匹林 / 抗凝剂治疗	Y 是 N 否	G.E. Reflux / heartburn 胃返酸 / 烧心	Y 是 N 否
Heart attack 心肌梗塞	Y 是 N 否	Hemophilia 血友病	Y 是 N 否	Gastrointestinal disease 胃肠道疾病	Y 是 N 否
Pacemaker 起搏器	Y 是 N 否	Abnormal bleeding 异常性出血	Y 是 N 否	AIDS or HIV positive 艾滋病或 HIV 阳性	Y 是 N 否
Heart murmur 心脏杂音	Y 是 N 否	Systemic lupus erythematosus 系统性红斑狼疮	Y 是 N 否	Epilepsy 癫痫	Y 是 N 否
Congenital heart defects 先天性心脏病	Y 是 N 否	Rheumatic fever 风湿热	Y 是 N 否	Neurological disorders 神经系统疾病	Y 是 N 否

High blood pressure 高血压	Y 是 N 否	Autoimmune disease 自身免疫性疾病	Y 是 N 否	Mental disorders 精神疾病 Type (类型):	Y 是 N 否
Low blood pressure 低血压	Y 是 N 否	Stroke 中风	Y 是 N 否	Hepatitis 肝炎 Type (类型):	Y 是 N 否
Anemia 贫血	Y 是 N 否	Diabetes 糖尿病 Type (类型) I II	Y 是 N 否	Liver disease 肝脏疾病	Y 是 N 否
Tuberculosis (TB) 肺结核	Y 是 N 否	Cancer / Tumor 癌症 / 肿瘤	Y 是 N 否	Kidney disease 肾脏疾病	Y 是 N 否
Asthma 哮喘	Y 是 N 否	Chemotherapy/Radiation therapy 化疗 / 放疗	Y 是 N 否	Osteoporosis 骨质疏松	Y 是 N 否
Sinus trouble 鼻窦炎	Y 是 N 否	Thyroid disease 甲状腺疾病	Y 是 N 否	Arthritis 关节炎	Y 是 N 否
Bronchitis / Emphysema 支气管炎/肺气肿	Y 是 N 否	Severe headaches/migraines 严重头痛 / 偏头痛	Y 是 N 否	Glaucoma 青光眼	Y 是 N 否
Lung disease 肺部疾病	Y 是 N 否	Sleep disorder 睡眠障碍	Y 是 N 否	Other Disease / Illness 其他疾病	Y 是 N 否

I understand the above information is necessary to provide me with dental care and I have answered all questions truthfully. (我理解上述信息对于牙科保健和治疗是必须的, 我如实地回答了上述问题)

Signature of Patient/ Guardian (病人/监护人签名): _____

Date (日期): _____

FOR COMPLETION BY DENTIST

Comments: _____
