



Date/日期: _____

PATIENT INFORMATION/患者資訊

Patient's Last name/患者姓氏 _____ First name/名字: _____ Middle Initial/中間名縮 _____

I prefer to be called/我比較喜歡被稱為: _____ Social Security/社會安全號碼#: _____ - _____ - _____

Birth Date/出生日期: ____ / ____ / ____ Age/年齡: _____ Sex/性別: Male/男 Female/女
MM DD YYYY

Home address/住家地址 _____

Cell phone/手機 (____) _____ - _____ Work phone/工作電話 (____) _____ - _____

Home Phone/住家電話 (____) _____ - _____ Email/電子郵件地址: _____

Preferred Appointment Confirmation Method/通知預約方式: Text / 短信 Phone Call/電話 Email/電子郵件

PARENT/GUARDIAN 家長 / 監護人

Patient lives with (check all that apply)/ 與患者同住 (勾選所有適用的人)

mother/母親 father/父親 stepmother/繼母 grandparents(s)/ 祖父母 Other/其他 _____

Father's full name/父親的全名 _____ Cell phone/手機 (____) _____ - _____

Email address/電子郵件地址 _____ Work phone/工作電話 (____) _____ - _____

Mother's full name/母親的全名 _____ Cell phone/手機 (____) _____ - _____

Email address/電子郵件地址 _____ Work phone/工作電話 (____) _____ - _____

Custodial parent(s) name/監護人父母姓名 _____

DENTIST/牙醫

Patient's dentist/患者的牙醫 _____ Office Phone/辦公室電話(____) _____ - _____

Address/地址, City/城市, State/州 _____

Last seen/上次看診 _____ Reason/原因 _____

Next appointment/下次約診 _____

Other dentists/dental specialists now being seen 現在看診的其他牙醫 / 牙科專科醫師: Name/姓名 _____

Office Phone/診所電話 (____) _____ - _____ Reason/原因 _____

GENERAL INFORMATION / 一般資訊

How do you know our office/ 您怎麼知道我們的診所? _____

- Sing Tao Newspaper/星島日報 Friend/朋友 _____
 Website/網站(Straightfinish.com) Existing Patient/現有患者 _____
 Website/網站(Dental Insurance) General Dentist/普通科牙醫 _____

Have any other family members been treated in this office? Please name them/有沒有其他家庭成員在這個診所接受治療? 請指名 _____

What concerns you about your teeth/您對牙齒有什麼擔憂? _____

Who suggested that you might need orthodontic treatment/誰建議您需要人齒顎矯正治療? _____

Have you had any previous orthodontic treatment or consultations/您以前是否曾接受任何的齒顎矯正治療或諮詢?

No/否 Yes/是, please describe/請說明 _____

Brother 兄弟/sister 姊妹 name 姓名 _____ age 年齡 _____ had orthodontic treatment/曾經接受齒顎矯正治療? No/否 Yes/是 If yes/如果是, where/在哪裡? _____

Brother 兄弟/sister 姊妹 name 姓名 _____ age 年齡 _____ had orthodontic treatment/曾經接受齒顎矯正治療? No/否 Yes/是 If yes/如果是, where/在哪裡? _____

Who will be responsible for bringing the patient to orthodontic appointments/誰將負責陪同患者赴齒顎矯正的預約?

DENTAL INSURANCE/牙科保險

Primary policy holder's full name/主要保單持有人的全名 _____ Birthday/生日 _____

Social Security#/社會安全號碼 _____ - _____ - _____ Relationship to patient/與患者的關係 _____

Insurance company/保險公司 _____ Employer/雇主 _____

ID#/ ID 編號 _____ Group#/團體編號 _____

Address/地址 _____

Dose this policy have orthodontic benefits/此份保單是否提供齒顎矯正服務? Yes/是 No/否 Don't Know/不知道

Secondary policy holder's full name/次要保單持有人的全名 _____ Birthday/生日 _____

Social Security#/社會安全號碼 _____ - _____ - _____ Relationship to patient/與患者的關係 _____

Insurance company/保險公司 _____ Employer/雇主 _____

ID#/ ID 編號 _____ Group#/團體編號 _____

Address/地址 _____

Dose this policy have orthodontic benefits/此份保單是否提供齒顎矯正服務? Yes/是 No/否 Don't Know/不知道

Your answer are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For following questions mark yes, no or don't know/understand (dk/u)

您的答案僅用於診所紀錄，而且完全保密。完整的病史對於充分的齒顎矯正評估相當重要。對於以下問題，請選擇是、否或不知道/瞭解 (dk/u)

MEDICAL HISTORY/病史

Now or in the past, have you had/現在或過去，您是否曾經有：

- 是 否 不知道 / 瞭解
- Yes no dk/u Birth defects or hereditary Problems/先天缺陷或遺傳性問題?
- Yes no dk/u Bone fractures, or major Injuries/骨折或重傷?
- Yes no dk/u Any injuries to face, head, Neck/臉部、頭部、頸部受傷?
- Yes no dk/u Arthritis or joint problems/關節炎或關節問題?
- Yes no dk/u Endocrine or thyroid problems/內分泌或甲狀腺問題?
- Yes no dk/u Diabetes or low sugar/糖尿病或低血糖?
- Yes no dk/u Kidney problems/腎臟問題?
- Yes no dk/u Cancer, tumor, radiation treatment or chemotherapy/癌症、腫瘤、輻射治療或化療?
- Yes no dk/u Stomach ulcer, hyperacidity, acid reflux 胃潰瘍、胃酸過多、胃酸逆流?
- Yes no dk/u Immune system problems/免疫系統問題?
- Yes no dk/u History of osteoporosis/骨質疏鬆症的病史?
- Yes no dk/u Gonorrhea, syphilis, sexually transmitted diseases/淋病、梅毒、性傳染病?
- Yes no dk/u AIDS or HIV positive/愛滋病或 HIV 陽性?
- Yes no dk/u Hepatitis, jaundice or other liver problems/肝炎、黃疸或其他肝臟問題?
- Yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia/小兒麻痺症、單核白血球增多症、肺結核、肺炎?
- Yes no dk/u Seizures, fainting spells, neurologic problem/癲癇發作、昏厥、神經系統問題?

- 是 否 不知道 / 瞭解
- Yes no dk/u Mental health disturbance or Depression/心理健康障礙或憂鬱?
- Yes no dk/u Vision, hearing, or speech Problems/視覺、聽覺或語言問題?
- Yes no dk/u History of eating disorder (anorexia, bulimia)/ 飲食失調病史 (厭食症、貪食症)?
- Yes no dk/u Asthma, sinus problems, Hayfever/哮喘、鼻竇問題、花粉過敏?
- Yes no dk/u Heart defects, heart murmur, rheumatic heart disease/心臟缺陷、心臟雜音、風濕性心臟病?
- Yes no dk/u Angina, arteriosclerosis, stroke or heart attack/心絞痛、動脈硬化、中風 或心臟病發作?
- Yes no dk/u Skin disorder (other than common acne)/ 皮膚疾病 (常見的痤瘡除外)?
- Yes no dk/u Do you eat a well-balanced Diet/您是否均衡飲食?
- Yes no dk/u Frequent headaches or Migraines/頭痛或偏頭痛頻繁?
- Yes no dk/u Frequent ear infections, colds, throat infections/頻繁耳部感染、感冒、喉嚨感染?
- Yes no dk/u Tonsil or adenoid condition/扁桃體或腺樣體病症?
- Yes no dk/u Do you frequently breathe through your mouth/您是否經常用嘴呼吸?
- Yes no dk/u Do you ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer/您是否曾經進行雙磷酸鹽類靜脈注射，例如 Zometa (zoledronic acid)、Aredia (pamidronate) 或 Didronel (etidronate) ，以治療骨骼疾病或癌症?

Yes no dk/u Do you ever taken oral bisphosphonates such as Fosama (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorder?/ 您是否曾經服用口服雙磷酸鹽類，例如 Fosama (alendronate)、Actonel (ridendronate)、Boniva (ibandronate)、Skelid (tiludronate) 或 Didronel (etidronate)，以治療骨骼疾病?

Yes no dk/u High or low blood pressure/高血壓或低血壓?
 Yes no dk/u Excessive bleeding or bruising tendency, Anemia/出血過多或瘀傷、貧血?
 Yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles/胸部疼痛、呼吸急促、易倦怠、腳踝腫大?

Have you had allergies or reactions to any of the following/您是否曾經對於以下任何一種出現過敏或反應:

是 否 不知道 / 瞭解

- Yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)/ 局部麻醉藥 (novocaine、lidocaine、xylocaine)
 Yes no dk/u Latex (gloves, balloons)/ 乳膠 (手套、氣球)
 Yes no dk/u Aspirin/阿司匹林
 Yes no dk/u Ibuprofen (Motrin, Advil)
 Yes no dk/u Penicillin/青黴素
 Yes no dk/u Metals (jewelry, clothing snaps)/ 金屬 (珠寶、服裝搭扣)
 Yes no dk/u Acrylics/丙烯酸
 Yes no dk/u Plant pollens/植物花粉
 Yes no dk/u Animals/動物
 Yes no dk/u Foods/食品
 Yes no dk/u Other substances/其他物質_____

PHYSICIAN/醫師

Patient's Physician/患者的醫師_____ City/市, State/_____

Last seen/上次看診_____ Reason/理由_____

Next appointment/下次約診_____ Most recent physical exam/最近一次身體檢查_____

Other physician/ health care providers being seen now/現在看診的其他醫師 / 照護提供者:

Name/姓名_____ City/城市, State/州_____

Reason/理由_____

Name/姓名_____ City/城市, State/州_____

Reason/理由_____

PATIENT HEALTH INFORMATION/患者健康資訊

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take. 列出任何藥物、營養補充劑、草藥或非處方藥，包括您服用的氟化物補充劑。

Medication/藥物 _____ Taken for/服用目的 _____

Medication/藥物 _____ Taken for/服用目的 _____

Have you ever taken any medications to strengthen your bones/您是否曾經服用任何藥物來強化您的骨骼? Please describe/請說明. _____

Do you take antibiotic pre-medication before any dental procedures/您是否在任何牙科手術之前預先服用抗生素?
 Yes/是 No/否

Do you or have you ever had a substance abuse problem/您或您曾經有藥物濫用問題? Yes/是 No/否

Do you chew or smoke tobacco/您是否咀嚼煙草或吸煙? Yes/是 No/否

Have you noticed any changes in your face or jaws/您是否注意到您的臉部或下顎出現任何變化? Yes/是 No/否

Any other physical problems/任何其他身體問題? Yes/是 No/否

How often do you brush/您多久刷一次牙? _____

How often do you floss/您多久使用一次牙線? _____

Women/女性: Are you pregnant/您是否懷孕? Yes/是 No/否

Women/女性: Are you trying to become pregnant/您是否在嘗試懷孕? Yes/是 No/否

FAMILY MEDICAL HISTORY/家庭病史

Have your parents or siblings ever had any of the following health problems? If so, please explain. 您的父母或兄弟姐妹是否曾經有以下任何健康問題? 如果有, 請說明

Bleeding disorders/出血性疾病 _____ Diabetes/糖尿病 _____

Arthritis/關節炎 _____ Severe allergies/嚴重過敏 _____

Unusual dental problems/異常牙科問題 _____ Jaw size imbalance/下顎大小不平衡 _____

Other family medical conditions/其他家庭醫療狀況? _____

RELEASE AND WAIVER/公佈和棄權

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company. 我授權向我的牙科和 / 或醫療保險公司公佈與我的齒顎矯正治療有關的任何資訊。

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completions of this form. I will notify my orthodontist of any changes in my medical or dental health. 我已閱讀並瞭解上述問題。我的齒顎矯正醫師或其任何員工對於我在填寫此表格時所造成的任何錯誤或遺漏負任何責任。我的醫療或牙齒健康方面有任何變化時, 我將通知我的齒顎矯正醫師。

Patient's name/患者姓名: _____ Patient's signature/簽名 _____

Guardian's name/監護人正楷姓名 _____ Guardian's signature/監護人簽名 _____

Date/日期 _____