

華埠牙醫診所

Canal Dental Group – Dental Form

Patient's Information 病人簡歷表

Insured's Information 保險公司資料

Patient's Name: 姓 Last _____ 名 First _____ 病人姓名: _____	Insured's Name: 姓 Last _____ 名 First _____ 保險持有人姓名: _____
Home Address 住址: City: _____ State: _____ Zip Code: _____	Home Address 住址: City: _____ State: _____ Zip Code: _____
Home Tel 住宅電話: _____	Home Tel 住宅電話: _____
Work Tel 工作電話: _____	Work Tel 工作電話: _____
Mobile Tel 手機: _____	Mobile Tel 手機: _____
Email 電子郵箱: _____	Email 電子郵箱: _____
Date of Birth: Month 月 / Day 日 / Year 年 出生日期: _____	Date of Birth: Month 月 / Day 日 / Year 年 出生日期: _____
Sex 性別: Male 男 _____ Female 女 _____	Sex 性別: Male 男 _____ Female 女 _____
Married Status 婚姻狀況: Married 已婚 _____ Single 單身 _____	Married Status 婚姻狀況: Married 已婚 _____ Single 單身 _____
Social Security No. 社安號碼: _____	Social Security No. 社安號碼: _____
Smoking 吸煙: _____ Yes/No	Insurance Plan Name 保險公司名稱: _____
Alcohol 酗酒: _____ Yes/No	Policy Group Name/No. 保險團體名稱/號碼: _____
Drug Abuse 濫用藥物: _____ Yes/No	Policy ID No. 保險號碼: _____
Allergy 過敏: None 沒有 _____ Medication 藥物 _____ Food 食物 _____ Other 其他 _____	
Past Medical History: 過去病史 High Blood Pressure 高血壓 Yes/No Heart Disease 心臟病 Yes/No Heart Murmur 心雜音 Yes/No Diabetes 糖尿病 Yes/No	Liver Disease 肝病 Yes/No Lung Disease 肺病 Yes/No Blood Disease 血液病 Yes/No Mental Disease 精神病 Yes/No
Stroke 中風 Yes/No Asthma 哮喘 Yes/No Cancer Disease Yes/No	
Surgery & Hospitalization 手術和住院	
Medication: 現服用藥物的名稱	
Family Medical History: 家庭病史	
Language 語言: Cantonese 廣東話 _____ Mandarin 國語 _____ English 英語 _____ Other 其他 _____	

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Canal Dental Group or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.
 我保證以上所有資料完整和準確。我亦明白以上資料只是用於我的疾病治療以及牙科保險申報。如果我填寫資料錯失而引起任何醫療和牙科保險申報的問題，華埠牙醫診所的醫生及其他工作人員不負任何責任。

Financial Agreement:

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that patients/guardians are responsible for all fees and services rendered for treatment of patient/ a minor/child. I accept full financial responsibility for all charges not cover by insurance.
 我明白除非有特殊安排，否則所有的治療費用都應在治療過程結束時付清，未成年病人的家長承擔未成年病人的治療費用。同時我亦會承擔并付清牙科保險沒有涵蓋的那部份費用。

Patient/Guardian (Print Name) _____ Relationship: Self _____ Spouse _____ Child _____ Other _____
 病人/監護人 姓名(正楷) _____ 與病人關係: 自己 _____ 配偶 _____ 子女 _____ 其他 _____

Signature 簽名 _____ Date 日期 _____