華康牙醫診所
Canal Dental Group

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)
病人/監護人 姓名(正楷)

Relationship: Self_____ Spouse_____ Child_____ Other_____
與病人關係: 自己 配偶 子女 其他

Signature 簽名 _____ Date 日期 _____