孩童看診及健康狀況表格

歡迎來到我們的診所! 請詳細填寫以下的表格, 為此我們可以了解及評估孩童的健康狀況和口腔上的需要, 謝謝您的合作!

兒童姓名:______ 暱稱:______ 生日:______ 性別:______
地址:______ 家裡電話:______
選擇聯絡方式: □發手機訊息 □電話聯絡 □電子郵件:______
藥房名稱和地址:______ 電話:______

父母/監護人: □媽媽 □爸爸 □其他______
姓名:______
生日:______ 社會安全號碼:______
公司名稱:______ 職業:______
公司電話:______ 手機號碼:______
主要保險
保險持有人:______
與孩童關係:______
保險公司名稱:______
保險卡號碼:______ 保險類目號碼:______

父母/監護人: □媽媽 □爸爸 □其他______
姓名:______
生日:______ 社會安全號碼______
公司名稱:______ 職業:______
公司電話:______ 手機號碼:______
次要保險
保險持有人:______
與孩童關係:______
保險公司名稱______
保險卡號碼::______ 保險類目號碼:______

若父母或監護人無法带您的孩子来看診, 是否有其他人您想要委托? 請註明他們和小孩是什麼關系?
(委托人會代替家長和監護人做所有關於牙齒治療方面的決定,無需通知家長和監護人)
名字:______ 关系:______

孩童病史: 小孩的兒科醫師 :______ 電話:______
您的小孩有沒有看過任何專科醫師 (神經科,心臟科, 腸胃科, 等等.):______
請問您的小孩是否有曾經因病或手術住院? □有 □沒有 為何原因?______
請問您的小要目前有無接受任何的藥物治療?______
請問您的小孩有無對任何食物或藥物過敏(包括消炎藥以及局部麻醉藥) ? □沒有 □有______
請問您的小孩是否有以下的疾病? 請圈選.

□過動症	□血液疾病	□飲食失調	□聽覺失調	□肝炎	□腫瘤/癌症
□ 過敏	□流血不止	□情緒失調	□心臟雜音	□腎臟疾病	□風濕痛
□ 貧血	□智力发育障碍	□癲癇	□心臟疾病	□學習障礙	□結核病
□ 氣喘	□糖尿病	□視覺失調	□愛滋病	□肝臟疾病	Other:______

您的小孩有無以下的習慣? □吸手指 □咬指夾 □吸奶嘴 □半夜喝奶 □沒有
您的小孩有需要早期教育吗?______
看牙紀錄: 這是您的小孩第一次看牙嗎? □是 □不是
如果不是, 之前牙醫的姓名______ 上次看診日期______
這是急症嗎: □是 □不是 看診的原因 :______
家中其他小孩有來過嗎? □有 □沒有 如果有, 他們的姓名及年齡______
請問是誰介紹您來的?______

同意背書: 因為您的小孩尚末成年, 因此在我們做任何診療之前, 必須先取得孩童父母或監護人的簽名同意. 再此.以下的簽名會被用於以上孩童在診療時所需的費用 . 保險方面: 我在此將所有保險給付金額授權給胡雪微兒童牙科, 我授權於胡雪微兒童牙科在必要時提供我的資料以確保醫療方面的給付. 我將以此簽名授權於所有保險費用的申請

我以此簽名授權於胡雪微兒童牙科, 授權/監護人簽名:______ 日期:______

CHILD'S REGISTRATION AND HEALTH HISTORY

WELCOME! Proper dental hygiene begins at an early age. Please fill out the following important information so we can make a thorough evaluation of your child's dental needs. Thank you for your cooperation!

Child's Name ____________ Nickname: ____________ Birth Date: ____________ ( ) M ( ) F

Social Security #: ____________ Home Phone: ____________ Age: ____________

Address: ____________ City: ____________ State: ____________ Zip: ____________

RESPONSIBLE PARTY: (If other parents, please state name and relationship) ____________

Name of Father: ____________

Date of Birth: ____________ SS#: ____________

Employer: ____________ Occupation: ____________

Work Phone: ____________

Cell Phone: ____________

Name of Mother: ____________

Date of Birth: ____________ SS#: ____________

Employer: ____________ Occupation: ____________

Work Phone: ____________

Cell Phone: ____________

PRIMARY DENTAL INSURANCE:

Person Responsible for Account: ____________

Relationship to Child: ____________

Insurance Company: ____________

Subscriber ID#: ____________ Group#: ____________

SECONDARY DENTAL INSURANCE:

Person Responsible for Account: ____________

Relationship to Child: ____________

Insurance Company: ____________

Subscriber ID#: ____________ Group#: ____________

MEDICAL HISTORY: Child's Physician or Pediatrician: ____________ Phone: ____________

Has your child ever been hospitalized for any illness, surgery? Yes____ No____ For? ____________

Is your child currently taking any prescription medications? ____________

Is your child allergic to any food or medicine including antibiotics and local anesthetic solutions? ____________

Does your child have a history of the following disorders: please circle Yes (Y) or No (N)

Y N Allergy	Y N Diabetes	Y N Hearing Disorder	Y N Kidney Disorder	Other ____________
Y N Anemia	Y N Eating Disorder	Y N Heart Murmur	Y N Liver Disorder	____________
Y N Asthma	Y N Emotional Disorder	Y N Heart Disorder	Y N Malignancy/ Neoplasm	____________
Y N Blood Disorder	Y N Epilepsy	Y N HIV/ AIDS	Y N Rheumatic Fever	____________
Y N Bleeding Disorder	Y N Eye Disorder	Y N Hepatitis	Y N Tuberculosis	____________

Does your child have any learning disability or ADD/ ADHD? ____________

DENTAL HISTORY: Is this your child's first dental visit? ____________ Reason for today's visit? ____________

Has your child ever had an unpleasant experience in a dental office: ____________

Does your child have any dental habits? ____Thumb/ finger sucking ____ Fingernail biting ____ Pacifier Habit ____ Bottle at night (with milk)

Name and Age of other children: ____________

How did you hear about our office? **Friend** ____________ **Newspaper** ____________ **Insurance Network:** ____________

Doctor ____________ **Other:** ____________

CONSENT: Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any/ or all necessary dental services are rendered. Furthermore, the undersigned will be responsible for any fee incurred on the above child for dental treatment rendered. INSURANCE: I also hereby authorize all insurance payment directly to Dr. Suet Wu, P.C., for all insurance benefits otherwise payable to me for services rendered. I authorize the above doctor in this office to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Authorization is hereby granted as such: Signature: ____________ **Date:** ____________