Dentistry（WEB）

year month day

Name	Male Female	Date of birth	Year Month Day
Address	〒 -	Phone	— —
Nationality		Phone	— —
Language	1. Jananese 2. English 3. German 4.Portuguese 5. Others ( )	Do you have insurance	1. YES 2.NO

Check all corresponding answers.

What is wrong with you?	1. toothache 2. gums hurt 3. filling fell out 4. teeth check-up 5. cleaning 6. crooked teeth 7. others（ ）
What illnesses have you had in the past?	1. heart disease 2. liver disease 3. kidney disease 4. asthma 5.AIDS 6. diabetes 7. high blood pressure（ / ） 8. others（ ） 9. no experience
Are you presently taking medication?	1. YES name（ ） 2. NO
Have you ever been allergic to medicine or food?	1. YES details ( ) 2. NO
Have you ever had any trouble with anesthesia or extraction?	1. YES details ( ) 2. NO
Are you pregnant?	1. YES （ week） 2. There is possibility 3.NO
Are you presently breastfeeding?	1. Yes 2. No
Your preferences for treatment	

上記に関して相違なければご署名をお願いいたします.

あおぞら歯科クリニック
AOZORA DENTAL CLINIC