DENTISTRY(Adult)

Date year month day

Katakana		Date of Birth	A.D. (year) (month) (day)
Name			Age (years old)
Address	〒		
Mobile phone		Telephone	

Check ☐ all corresponding answers.

◎What are your symptoms?

☐Crooked Teeth ☐Teeth check-up ☐ Teeth cleaning ☐Cavity ☐Toothache
☐Swelling ☐Worried about the Color of may teeth ☐Filling・Fell out
☐Loose tooth ☐New dentures・Implant ☐Others（ ）

◎Where do the symptom?

（ ）

◎When did the symptom start?

（ ）

◎Do you have any food or medication allergies?

☐No ・☐Yes （ ）

◎ Do any of the dollowing general medical conditions apply?

☐High blood pressure(/) ☐Heart Disease（ ） ☐Diabetes ☐Asthma
☐Thyroid problems（ ） ☐Gastrointestinal disease（ ）
☐Kidney disease（ ） ☐Liver disease（ ） ☐Osteoporosis
☐Pregnant ☐Breastfeeding ☐Others（ ）

◎Are you currently taking medication? Please pass if you have medicine notebook.

☐No ・ ☐Yes （ ）

◎Did you have any problems related to the anesthesia or tooth extraction？

☐No ・ ☐Yes （ ）

◎How are you feeling today?

☐Fine ☐Fever ☐Tiredness ☐Insufficient sleep ☐Others（ ）

◎Please tell me your request for the treatment.

☐I would like to have the entire damaged area treated.
☐I would like to have only the teeth that currently hurt treated.
☐I would like to have treatment that best way.
☐I don't mind paying for treatment that is not covered by insurance
☐I would like to have only treatment that is covered by insurance.
☐I can't open my mouth for a long time.
☐Reservation Request _____ (Day of the week) _____(O'clock)
☐Others（ ）

◎What made you come to our clinic？

☐Neighborhood ☐Family or Acquaintance（Name ） ☐Website
☐KOUTOUKUJIKAN ☐PADO ☐Pamphlet ☐Others（ ）

◎ Do you have other request？

（ ）

DENTISTRY(Children)

Date year month day

Katakana		Date of Birth	A.D. (year) (month) (day) Age (years old)
Name			
Address	〒		
Parent's phone	Relationship ( )	Home phone number	

Check ☐ all corresponding answers.

◎What are your symptoms?

☐Crooked Teeth ☐Teeth check-up ☐ Teeth cleaning ☐Cavity ☐Toothache
☐Swelling ☐Worried about the Color of my teeth ☐Filling・Fell out
☐Loose tooth ☐ Hit teeth or jaws ☐Others（ ）

◎Where do the symptom?（ ）

◎When did the symptom start?（ ）

◎Is it your child first dental treatment? ☐First ☐Experienced（ ）(years old)

◎Could your child got treatment? ☐Yes ・☐No（ ）

◎Did your child have any problems related to the anesthesia or tooth extraction？

☐No ・ ☐Yes（ ）

◎Please tell me about Birth abnormality, chronic illness, medical history

Birth weight（ g）Notices（ ）
Chronic illness（ ）Medical history（ ）

◎Do your child have any food or medication allergies?

☐No ・☐Yes（ ）

◎Are your child currently taking medication? Please pass if you have medicine notebook.

☐No ・ ☐Yes（ ）

◎How are you feeling today?

☐Fine ☐Fever ☐Tiredness ☐Insufficient sleep ☐Others（ ）

◎What is your child's personality?

☐Spoiled child ☐Cry baby ☐Quiet ☐Active ☐Others（ ）

◎Children's nickname（ ）◎What is your child's favorite?（ ）

◎What made you come to our clinic？

☐Neighborhood ☐Family or Acquaintance（Name ） ☐Website
☐KOUTOUKUJIKAN ☐PADO ☐Pamphlet ☐Others（ ）

◎In this hospital, if you wish, we can offer active treatment for children who are afraid of dental treatment and strongly resist, if you wish, under the control of the body (wrapping with a towel etc.) , The decision is asked to parents. Would you like it? ☐Yes ☐No

◎ Do you have other request？

（ ）