

No. _____

Name _____

Date of Birth / / Sex Male Female

Address ̄ _____

Phone number E-mail address

Occupation _____

Nationality _____

Do you have health Insurance?

Yes No

What are your symptoms?

- toothache filling fell out gums hurt/bleeding
- cavity teeth check-up teeth cleaning bad breath
- would like to make new dentures broken dentures
- others _____

Do you have any food or medication allergies?

- yes I am allergic to _____.
- no

Are you currently taking medication?

- yes I am taking _____.
- no

Have you ever had any trouble with anesthesia?

- yes no

Have you ever had a tooth removed?

- yes no

Are you pregnant or is there possibility of pregnancy?

yes no

Are you currently breastfeeding?

yes no

What illnesses have you had in the past?

stomach and intestinal disorder liver disease heart disease
kidney disease tuberculosis diabetes asthma

Your preferences for treatment?

I want to have all my teeth problems fixed
I prefer not to have teeth extracted unless it is absolutely necessary
I want to have treatment within the limits of my health insurance coverage
I want to decide the treatment after consulting with the doctor

How did you know about Anzai Dental Office?

Anzai Dental Office Website Facebook
Google Bugle Friend _____(name)
others _____