ORTHO WORKS®
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DAVID SHEN, D.M.D. & ASSOCIATES
SPECIALISTS IN ORTHODONTICS & INVISALIGN®

CHILD PATIENT INFORMATION
儿童患者信息

PATIENT INFORMATION (Please Print) 患者信息(请使用手写体)

Patient's Name _____ **Date of Birth** _____ **M** **F**
患者姓名 **出生日期** **男** **女**
Last 姓 First 名 Middle 中间名 Month 月 / Day 日 / Year 年

Address _____ **Phone** (_____) _____
地址 **电话**
Street 街道 City 城市 Zip Code 邮编

School _____ Siblings _____
学校 兄弟姐妹

Referred By _____ Patient E-Mail _____
推荐人 患者电子邮箱

Dentist _____ Phone (_____) _____
牙医 电话

Physician _____ Phone (_____) _____
家庭医生 电话

Mother's Name _____ **Father's Name** _____
母亲姓名 **父亲姓名**
Last 姓 First 名 Middle 中间名 Last 姓 First 名 Middle 中间名

Social Security Number _____ Social Security Number _____
社安号 社安号

Home Address _____ Home Address _____
家庭地址 家庭地址

Phone (_____)_____(_____)_____ Phone (_____)_____(_____)_____
电话
Home 家庭电话 Work or Emergency 工作或紧急联系电话 Home 家庭电话 Work or Emergency 工作或紧急联系电话

Cell Phone (_____)_____ Email _____ Cell Phone (_____)_____ Email _____
手机号码 电子邮箱 手机号码 电子邮箱

Employer _____ Employer _____
雇佣单位 雇佣单位

Work Address _____ Work Address _____
工作地址 工作地址

Is patient covered by orthodontic insurance? □ **Yes** □ **No**
患者是否有牙科保险? **是** **否**

If yes, please complete the following information.
如果是，请完整填写下列信息。

IF YOU HAVE COVERAGE FROM MORE THAN ONE COMPANY, PLEASE GIVE ALL INFORMATION FOR EACH COMPANY.
如果你有多个保险公司，请提供每一个保险公司的具体信息。

Name of Insurance Company 保险公司名称 | Name of Policy Holder 持保人姓名 | Date of Birth 生日

Policy Holders' Employer(s)持保人雇佣单位 | Union Local Number(s)当地工会号 | Employer Group Number 雇佣单位组号

Person Responsible for Account 保险责任人 _____

(If person other than above, please give address, phone and relationship.)
（如果保险责任人不是患者本人，请写明地址，电话及与患者的关系。）

Name 姓名: _____

DENTAL HISTORY 牙科病史

Date of last dental care 上一次看牙医的日期 _____

Family history of orthodontic problems 牙科矫正家庭史_____

Were there any habits which might have caused the teeth to move? (i.e. nail or lip biting, thumbsucing, etc.) _____
是否有任何习惯可能导致牙齿移动？（例如咬指甲，咬嘴唇，吸拇指等）

Has an orthodontist been consulted previously? _____
以前是否咨询过矫牙医生？

What is your main concern? _____
你最担心什么问题？

	Yes 是	No 否
Has there been any injuries to the face, mouth or teeth? . . . . . 面部，嘴部或牙齿是否受过伤害？	□	□
Does the patient have any speech problems? . . . . 患者是否有语言障碍？	□	□
Are there any missing or extra permanent teeth?. . . . . . 是否有缺失或多余的牙齿？	□	□
Does patient have clenching or grinding habits? . . . . 患者是否有咬牙或磨牙的习惯？	□	□
Does patient have sore or sensitive teeth?. . . . . 患者是否牙疼或有敏感性牙齿？	□	□
Has patient ever had any orthodontic treatment? . . . . . . 患者曾经是否做过牙齿矫正？	□	□

List any musical instruments played by mouth_____
请列出患者使用嘴唇吹奏的乐器

_____

ORAL HYGIENE
口腔卫生

	Yes 是	No 否
Is patient self-conscious about the appearance of his/her teeth? 患者是否对自己的牙齿外观感到难为情？	□	□

ORAL HYGIENE
口腔卫生

	Yes 是	No 否
Has a dentist or hygienist shown patient how to clean your teeth? 牙医或洁齿师是否为患者展示过怎样清洁你的牙齿？	□	□
Does patient still use these methods? . . . . . . 患者还在使用那些方法清洁牙齿吗？	□	□

How often does patient brush his/her teeth? _____
患者多久刷一次牙？

List type of toothbrush: □ hard □ medium □ soft
使用何种类型的牙刷　　硬毛　不软不硬　软毛

List any other aids: □ floss □ Stimudent □ water spray device
其他洁齿工具：　　牙线　牙菌清除器　喷水器
☐ rubber tip □ toothpick □ other _____
橡胶头　　牙签　　其他

How often used: _____
洁齿工具使用频率

When was the last professional dental cleaning? _____
上一次专业洁齿是在何时？

How often scheduled? _____
多久预约一次专业洁齿？

Additional general dental information:
一般牙科附加信息：_____

_____

_____

Name 姓名: _____

MEDICAL HISTORY 病史

Date of last medical care 上一次医疗检查的时间 _____

Has your child been a patient in a hospital in the past 2 years? □ Yes □ No Reason: _____

你的孩子在过去两年里是否住过院？ 是 否 原因

Health is □ Excellent □ Good □ Fair □ Poor

健康状况 优 良 一般 差

Do any of the following pertain to your child? *(Please check yes or no to each.)*
你的孩子是否有下列任何症状？（请对每项进行选择是或者否）

	Yes 是	No 否
1. Allergies.	□	□
过敏		
a) Penicillin or other Antibiotics	□	□
青霉素或其他抗生素过敏		
b) Local anesthetic	□	□
局部麻醉剂过敏		
c) Metal	□	□
金属过敏		
d) Latex	□	□
胶乳过敏		
e) Other	□	□
其他过敏		
2. Arthritis	□	□
关节炎		
3. Asthma	□	□
哮喘		
4. Blood Disease or Abnormal Bleeding Problems . .	□	□
血液病或异常出血		
a) Anemia	□	□
贫血		
b) Clotting problems	□	□
凝血		
c) Excessive bleeding requiring treatment	□	□
失血过多需要进行治疗		
d) Other blood disorders.	□	□
其他血液疾病		
5. Chest Pains, Ankle Swelling or Shortness of	□	□
胸痛，脚踝肿胀或呼吸急促		
6. Diabetes	□	□
糖尿病		
Occurrence in immediate family	□	□
直系亲属中有糖尿病患者		
7. Epilepsy.	□	□
癫痫		
8. Fainting 晕厥.	□	□
9. Glandular Disease (thyroid, etc.).	□	□
腺性疾病(甲状腺等)		

	Yes 是	No 否
10. Heart Disease	□	□
心脏病		
11. Heart Murmur.	□	□
心脏杂音		
12. Rheumatic Fever	□	□
风湿热		
13. High Blood Pressure	□	□
高血压		
14. Low Blood Pressure	□	□
低血压		
15. Kidney Disease	□	□
肾脏疾病		
16. Liver Disease, Hepatitis, Jaundice	□	□
肝脏疾病，肝炎，黄疸		
17. Psychiatric Treatment	□	□
精神治疗		
18. Radiation Treatment.	□	□
放射治疗		
19. Respiratory Disease.	□	□
呼吸道疾病		
20. Stomach or Duodenal Ulcers	□	□
胃溃疡或十二指肠溃疡		
21. Tumor History	□	□
肿瘤史		
22. Venereal Disease	□	□
性病		
23. A.I.D.S. / HIV + ...	□	□
艾滋病 / 阳性艾滋病毒		
24. Joint Replacement	□	□
关节置换手术		
25. Phen-Fen or Diet Drugs.	□	□
Phen-Fen 或减肥药		
26. Bisphosphonates.	□	□
二磷酸盐		
27. Other medical concerns: _____		
其他医疗问题		

Name 姓名: _____

	Yes 是	No 否
28. Is patient taking medicine, drugs or pills regularly? . . . . . 患者是否经常服药？	□	□
If so, name of medication(s) _____ 如果是，请列出药物名称		
29. Does patient require pre-medication with antibiotics prior to dental treatments (based on physician's instructions)? . . . . . 患者是否需要在牙科治疗前(根据医生指示)使用抗生素？	□	□
If so, name of medication(s) _____ 如果是，请列出药物名称		
30. Has patient experienced any unfavorable reaction to previous dental treatments? . . . . . 患者在以前的牙科治疗中是否出现过不良反应？	□	□

Please explain particulars regarding any "yes" answers given above: _____

在上述选择中如果有任何答案选择了"是"请详细说明：

_____

_____

ACKNOWLEDGEMENT AND AUTHORITY
认证和授权

I consent to treatment as necessary or desirable to the care of the patient first named above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor or his nurse or qualified designate.

我同意主治医生或他的护士或他指定的合格人士对上述患者进行治疗，在治疗过程中包括，但不限于使用任何药物，实施手术，进行实验室研究，拍摄 X 射线或进行其他研究。

I also acknowledge full responsibility for the payment of such services and agree to pay for them. OrthoWorks Dental Group may run a credit report on me and/or my guarantor.

我也承认并同意支付此项服务的全部费用。OrthoWorks Dental Group 可能会查询我或我的担保人的信用报告。

I authorize assignment of insurance benefits payable to OrthoWorks.

我授权保险公司将保险费支付给 OrthoWorks。

Signed 签名 _____ Date 日期 _____

Patient, Parent or Agent (Must be 18 years or older)
患者，家长或代理(18 周岁以上)

There is no change, to my personal knowledge, on my medical history.
据我所知，我的病史没有任何改变。

Medical History Reviewed:
病史复合员：

Date: 日期	Initial: 姓名首字母	Date: 日期	Initial: 姓名首字母	Date: 日期	Initial: 姓名首字母	Date: 日期	Initial: 姓名首字母
_____	_____	_____	_____	_____	_____	_____	_____