医療法人社団 爽志会 CELEO HACHIOJI CLINIC
セレオ八王子歯科クリニック

New Patient Dental Questionnaire

(Confidential Information)

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Gender:** ☐Male ☐Female ☐Other
- **Phone Number:** _____
- **Email Address:** _____
- **Address:** _____
  _____

Emergency Contact

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

Insurance Information

Basic dental services including routine tooth cleaning, cavity fillings, root canals, and crowns are all covered under National Health Insurance/kokumin kenko-hoken (NHI) and Employee Health Insurance/shakai kenko-hoken (EHI).

- Do you have Dental Insurance?
  ☐Yes ☐No
  If yes,
  ☐Japanese National Health Insurance/kokumin kenko-hoken (NHI) and Employee Health Insurance/shakai kenko-hoken (EHI).
  ☐Private or Travel insurance.
  If your insurance provider requires specific forms, please let us know so that we can accommodate.

  Insurance Provider: _____
  Policy Number: _____

Dental History

- What is the reason for your visit today?
  _____
  _____
- Date of last dental visit: ____ / ____ / _____
- Have you had any of the following? (Check all that apply)
  ☐Tooth pain
  ☐Tooth sensitivity (hot/cold/sweets)
  ☐Gum problems (pain/bleeding/Swelling)
  ☐Detachment of the restoration/ Filling come off
  ☐Denture problems
  ☐Teeth alignment
  ☐Teeth whitening
  ☐Jaw pain or clicking
  ☐Difficulty chewing
  ☐Sleep apnea/Snoring
  ☐Bad breath
  ☐Other: _____
- Are you currently having:
  ☐Dental implants
  ☐Dentures
  ☐Braces

☐Night guard
☐Other: _____

- Have you ever had any complications with Local dental anesthesia/ Tooth Extractions?
  ☐Yes ☐No
  If yes, please explain: _____
- Do you feel nervous about dental treatment?
  ☐Yes ☐No
  If yes, please explain: _____

Medical History

- Do you have or have you had any of the following conditions? (Check all that apply)
  ☐Heart disease
  ☐High blood pressure
  ☐Diabetes
  ☐Asthma
  ☐Epilepsy/seizures
  ☐Liver disease
  ☐Kidney disease
  ☐Cancer
  ☐Osteoporosis
  ☐HIV/AIDS
  ☐Hepatitis A / B / C
  ☐Syphilis
  ☐Other: _____
- Are you currently taking any medications?
  ☐Yes ☐No
  If yes, please list them:
- Do you have any allergies (including medications)?
  ☐Yes ☐No
  If yes, please list them:
- Have you ever had any complications with anesthesia?
  ☐Yes ☐No

- Are you pregnant or breastfeeding?
  ☐Yes ☐No ☐N/A

Lifestyle

- Do you smoke? ☐Yes ☐No
- Do you drink alcohol? ☐Yes ☐No
- Do you grind or clench your teeth? ☐Yes ☐No
- How often do you brush your teeth?
  ☐Once a day ☐Twice a day ☐More than twice ☐Occasionally
- Do you use dental floss? ☐Daily ☐Occasionally ☐Never

Accepted Payment Methods

We accept cash only for treatments covered NHI/EHI and cash and credit cards (Visa/ Master) for treatments not covered by NHI/EHI.

How did you know/hear about our clinic? : _____

Signature

I confirm that the information provided above is accurate and complete to the best of my knowledge.

Signature: _____

Date: ____ / ____ / _____

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