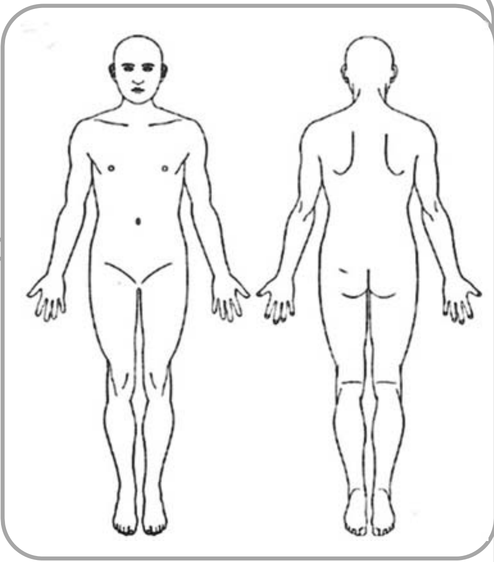
Date : _______/_______/_______

REGISTRATION

Kana Syllables			
Name		Gender	
Birth Date	Year/ Month/ Day / / (Yrs.- old)		
Address In Japan	Zip ー		
Telephone	Home : - - ／Mobile - -		
Occupation		Company	

- If you have any symptoms listed below, check them.
  ☐Fever ☐Whole body rash ☐Severe pain ☐Bleeding ☐Fresh burn
- Do you have any disabilities?
  ☐Walking (Wheel chair/ Stick) ☐Hearing ☐Eye sight ☐Dementia ☐Others__________

- Mark the site(s) you concern.
- Symptoms: None / Itch / Pain / Others______________
- Since:____days,____weeks,____months,____years ago
- What was the previous diagnosis?



- Past sickness:___________________________________
- Present sickness:________________________________
- Present medication:______________________________

  ____
- Allergy to any medicine: None/ Yes________________
- Troubles with local anesthesia :None/ Yes
- Pregnancy: No/ Yes (_____months), Breast feeding: No/ Yes

- Reason(s) you chose us.
  ☐Referral from other doctor ☐Recommendation of family ☐of friend______________
  ☐On line search ☐Easy access ☐Others____________________________________
- Do you have any special request upon seeing doctor?