# DENTAL REGISTRATION AND HISTORY

DENTAL HISTORY **치과기록**

|  |  |  |
| --- | --- | --- |
| Reason for today’s visit **치과방문이유**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_  *Highlight “yes” or “no” if you have had any of the following:* Bad breath YES NO Bleeding gums YES NO Blisters on lips or mouth YES NO Burning sensation on tongue YES NO | Chew on one side of mouth YES NO Cigarette, pipe, cigar smoking YES NO Clicking or popping jaw YES NO Dry mouth YES NO Fingernail biting YES NO Food collection between the teeth YES NO Foreign objects YES NO Grinding teeth YES NO Gums swollen or tender YES NO Jaw pain or tiredness YES NO Lip or cheek biting YES NO Loose teeth or broken fillings YES NO | Mouth breathing YES NO Mouth pain, brushing YES NO Orthodontic treatment YES NO Pain around ear YES NO Periodontal treatment YES NO Sensitivity to cold YES NO Sensitivity to hot YES NO Sensitivity to sweets YES NO Sensitivity when biting YES NO Sores or growths in your mouth YES NO How often do you floss?**치실횟수**\_\_\_\_\_\_\_\_ How often do you brush?**양치횟수** \_\_\_\_\_\_\_ |
|  |  |  |

PHONE NUMBERS**전화번호, 응급연락처**

Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_  
Spouse’s work (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Best time and place to reach you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)**응급연락처**   
Name **이름** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship **환자와의 관계**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Cell phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PATIENT INFORMATION* **환자정보**

Date **날짜**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Name **이름**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address **주소**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Sex (*please highlight*) Male**남자** Female**여자**  
Birth date **생년월일**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email **이메일**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please highlight:***결혼여부**Married Widowed Single Minor  
Separated Divorced Partnered for \_\_ years

Patient Employer/School**직장/학교**\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Occupation **직업**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employer/School Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Spouse’s employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_

DENTAL INSURANCE **보험정보**

Who is responsible for this account? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insurance Company**보험회사** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Is the patient covered by additional insurance?*  **Y** or **N**Subscriber’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE**I certify that I, and/or my dependent(s), have insurance coverage with \_\_*(name of insurance company)*\_\_ and assign directly to Dr. \_\_\_\_\_\_ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.  
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed.  
**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_