#  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 NOBleeding gums YES NOBlisters on lips or mouth YES NOBurning sensation on tongue YES NO | Chew on one side of mouth YES NOCigarette, pipe, cigar smoking YES NOClicking or popping jaw YES NODry mouth YES NOFingernail biting YES NOFood collection between the teeth YES NOForeign objects YES NOGrinding teeth YES NOGums swollen or tender YES NOJaw pain or tiredness YES NOLip or cheek biting YES NOLoose teeth or broken fillings YES NO | Mouth breathing YES NOMouth pain, brushing YES NOOrthodontic treatment YES NOPain around ear YES NOPeriodontal treatment YES NOSensitivity to cold YES NOSensitivity to hot YES NOSensitivity to sweets YES NOSensitivity when biting YES NOSores or growths in your mouth YES NOHow 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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_