New Patient Information (환자 정보)

저희 치과를 찾아주셔서 감사합니다. 최선의 치료와 서비스를 환자분께 제공하기 위해 환자분의 기본정보와 건강상태나 그동안의 의료기록을 작성 부탁드립니다. 여기에 작성하시는 모든 내용은 환자분 이외의 누구에게도 제공되지 않습니다. 설문작성에 시간을 내주셔서 미리 감사합니다.

Name (성명) _____

Email (이메일) _____

Male (남) ____ Female(여) ___ / Married (기혼) ____ Single (미혼) ____

Birthdate(생년월일) _____

Social Security# (소셜시큐리티 번호): _____

Driver's License# (운전면허 번호) : _____

주소:

Street _____City_____ State_____ Zip_____

Home # (집 번호) _____ Cell# (핸드폰 번호) _____

직장정보:

Employer(직장) _____

Street _____City_____ State_____ Zip_____

How Long There? (일하신 기간) _____Tel #(직장 번호) _____

보험정보:

Subscriber #(보험아이디 번호) _____

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Social Security#(소셜시큐리티 번호)_____Birthdate(생년월일):_____

Insurance Co.(보험회사 이름) _____

Group#(그룹번호)_____ Phone#(보험회사 번호) _____

환자분 병력란 :

1. Your current physical health is (현재 건강상태) : ☐ Good ☐Fair ☐Poor

2. Do you smoke or use tobacco in any other form? 흡연 중이십니까? ☐ Yes ☐ No

3. Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No
드시는 약이 있으십니까?
* Which ones / 무엇입니까? _____

4. Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No
포사맥스나 골다공증 약품을 드신적이 있으십니까?

5. Have you ever taken Phen-Fen? ☐ Yes ☐ No
펜테르민/훼플루라민을 드신적이 있으십니까?

6. Are you under a physician's care now? 치료 중이십니까? ☐ Yes ☐ No
If so, please give reason for treatment: _____
무슨 치료를 받으십니까?
Physician's Name: _____
의사이름
Telephone: _____
병원 전화번호:

For Women : (여성분들)
7. Are you using a prescribed method of birth control? 처방받은 경구 피임약을 복용 중이십니까?
☐ Yes ☐ No

8. Are you pregnant? 임신 중이십니까? ☐ Yes ☐ No
Week (몇주) #: _____

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9. Have you ever had any of the following diseases or medical problems?

☐ : Abnormal Bleeding 심한출혈
☐ : Herpes / Fever Blisters 포진
☐ : Alcohol / Drug Abuse 술/약물남용
☐ : High Blood Pressure 고혈압
☐ : Psychiatric Problems 정신병
☐ : Emphysema 폐기종
☐ : Radiation Treatment 방사선 요법
☐ :: Epilepsy 뇌전증
☐ : Rheumatic / Scarlet Fever 류마치성열
☐ : Fainting Spells 실신
☐ : Seizures 뇌졸중
☐ : Frequent Headaches 두통
☐ : Stroke 뇌졸중
☐ : Heart Murmur 심잡음
☐ : Thyroid Problems 갑상선
☐ : Heart Surgery 심장수술
☐ : Tuberculosis (TB) 결핵
☐ : Sinus Problems 코의 염증

☐ : Anemia 빈혈 Y N HIV+ / AIDS 에이즈
☐ : Arthritis 관절염
☐ : Hospitalized for Any Reason 입원
☐ : Artificial Bones / Joints / Valves 인공뼈
☐ : Kidney Problems 콩팥질환
☐ : Asthma 천식
☐ : Liver Disease 간장질환
☐ : Shingles 대상 포진
☐ : Glaucoma 녹내장
☐ : Sickle Cell Disease/ Traits 겸상 적혈구성 빈혈
☐ : Hay Fever 고초열
☐ : Sinus Problems 코의 염증
☐ : Heart Attack 심장마비
☐ : Stroke 뇌졸중
☐ : Hepatitis 간염
☐ : Venereal Disease 성병

☐ : Blood Transfusion 수혈
☐ : Low Blood Pressure 저혈압
☐ :: Cancer / Chemotherapy 암
☐ : Lupus 낭창
☐ : Colitis 대장염
☐ : Mitral Valve Prolapse 승모판 탈출증
☐ : Congenital Heart Defect 선천성 심장병
☐ : Osteoporosis / Paget's Disease 골다공증
☐ : Diabetes 당뇨병
☐ : Pacemaker 인공 심장박동기
☐ : Difficulty Breathing 호흡곤란
☐ : Frequent Headaches 두통
☐ : Shingles 대상 포진
☐ : Glaucoma 녹내장
☐ : Sickle Cell Disease/ Traits 겸상 적혈구성 빈혈
☐ : Hay Fever 고초열
☐ : Hemophilia 혈우병
☐ : Ulcers 궤양
☐ : Tuberculosis (TB) 결핵
☐ : Heart Attack 심장마비

Please list any serious medical condition(s) that you have ever had:
건강에 대하여 참고 할 만한 사항 있으시면 기록하십시오: _____

10. Are you allergic to any of the following? / 이 중에서 알레르기가 있으십니까?

☐ : Aspirin 아스피린
☐ : Codeine 코데인
☐ : Dental Anesthetics 치과 마취
☐ : Erythromycin 에리스로마이신
☐ : Latex 라텍스AIDS 에이즈
☐ : Penicillin 페니실린
☐ : Tetracycline 테트라사이클린
☐ : Other 기타

Please list any other drugs/materials that you are allergic to:
이 외에 알레르기 있으신 약들을 기록하십시오 : _____

What is the reason for your visit today? 오늘 치과를 방문하신 목적이 무엇입니까?

_____

Date of last dental visit 마지막으로 치과 방문하신 날짜 (월/년) _____

What was done on your last dental visit? 마지막으로 치과 방문시 치료내용 _____

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How often do you have dental examination? 얼마나 자주 치과 검진을 받으시나요? _____

How often do you brush your teeth? 얼마나 자주 양치를 하십니까? _____

How often do you floss? 얼마나 자주 치실을 사용하십니까? _____

What other dental aids do you use? 다른 치아 관리 도구를 사용하십니까? (이쑤시개,진동칫솔,등등)

_____

Do you have any dental problems now? 지금 치아에 문제가 있으십니까? (그렇다면, 설명해주세요)

_____

☐ Y ☐ N : 교정기를 하신적 있으신가요?	☐ Y ☐ N : 혓바늘 또는 입안 물집이 자주 생기나요?
☐ Y ☐ N : 치주염 치료를 받으신적 있나요?	☐ Y ☐ N : 교정기를 하신적 있으신가요?
☐ Y ☐ N : 뜨거운/찬 음식 드실때 불편하신가요?	☐ Y ☐ N : 사랑니 발치 하신적 있으신가요?
☐ Y ☐ N : 입냄새가 나거나 쓴맛을 느끼십니까?	☐ Y ☐ N : 마우스가드/마우스피스 사용하신적 있으신가요?
☐ Y ☐ N : 양치하실때 피가 나시나요?	☐ Y ☐ N : 구강외과 치료를 받은적 있으신가요?

WORK AUTHORIZATION & FINANCIAL POLICY

The undersigned hereby authorizes the Doctor to take x-rays, study, models photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risks. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a Finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor. We respect that your time is valuable, please respect ours also, therefore, if appointments are continuously cancelled or charged without a 48hr notice; we require a reservations fee for future appointments.

Patient's (Guardians) Signature _____

Date _____

Dentist Initials _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. PATIENTS RIGHTS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. You may request a copy of our Notice at any time.

Do we have your permission to send your information pertaining to our services by email? 서비스와 관련된 정보를 이메일로 보낼 수있는 권한이 있습니까? **Yes____ No____**

Do we have your permission to remind you by telephone or email of any appointment at home or mobile number? 집이나 휴대폰 번호로 약속을 전화 나 이메일로 알려줄 수있는 권한이 있습니까? **Yes____ No____**

Do we have your permission to discuss any health information related to you with your family member, friend, or other person? 귀하와 관련된 건강 정보를 가족, 친구 또는 다른 사람과 논의 할 수있는 권한이 있습니까? **Yes____ No____**

By my signature below, I acknowledge that I have received the Notice of Privacy Practices from the office Complete Smile.

_____

Name

_____

Signature

_____

Date

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PATIENT AGREEMENT FORM

Thank you for choosing Complete Smile as your dental treatment provider. In order to facilitate your treatment here we ask that you read and sign this agreement. If you have any questions, please ask for clarification.

For the patients with dental insurance, we will gladly verify and process your dental insurance with the following agreement:

☐ Your dental insurance is an agreement between you and your insurance company. 치과 보험은 귀하와 귀하의 보험 회사와의 계약입니다.

☐ All patient copayments and/or patient portions are only an estimate and never guarantee of payment. 모든 환자의 co-payment 및 / 또는 환자의 estimate 가격은 보장되지 않은 가격입니다. 환자분의 보험회사에 따라 가격 변경이 있을수 있습니다.

☐ As part of your contract with your insurance company, you are responsible for all out-of-pocket fee / deductibles and copayments. 환자분과 보험회사와의 계약의 일부로, 환자는 추가되는 비용과 공제액 및 다른 부담금을 책임집니다.

☐ Insurance payments not paid after 90 days will become your complete responsibility and must be paid in full. 90일 이후에 지불 되지 않은 보험료는 환자의 책임이 있으며 전액 지불해야 합니다.

Missed Appointment or Short Notice Cancellations/ Reschedules:

We understand that your plans/ schedules can change. When they do, please contact us at least **48 hours** in advance. A fee of **$50** will be charged to cancelations/ reschedules with less than 48 hours or with no notice prior to your appointment.

By my signature below, I acknowledge that I have reviewed the patient agreement form and agree to the terms and policies. 환자분의 계획 또는 스케줄이 변경 될수 있음을 이해합니다. 최소 48 시간 이내에 또는 예약 전에 통지 없이 일정을 변경하실 경우 $50 불 수수료가 부과 됩니다. 스케줄 변경은 48 시간 이전에 연락주셔서 변경해주시기 바랍니다. 아래 서명으로 본인/환자가 이 동의서 약식과 이용 약관 검토하였고 동의 합니다.

_____

Name

_____

Signature

_____

Date

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