Christian Dental Arts

PATIENT INFORMATION

Patient Name (영문 환자 명): _____ DOB (생년월일): _____/_____/_____

Cell Phone (휴대전화): (_____) - _____ - _____ SS#: _____

Address (주소):_____ SEX (성별): M F

City:_____ State:_____ Zip: _____

Emergency Contact Name: _____ Emergency Contact Phone number: _____

Emergency Contact Relationship: _____ 소개받으신 분이나 받으신 곳: _____

DENTAL HISTORY (치과병력)

Chief Complaint (오늘 방문하신 이유)

_____

Last Dental Visit (마지막으로 치과 방문하신 날짜)

_____

MEDICAL HISTORY (의료정보)

Physician's Name (의사정보):

_____

List of Medications (현재 복용 중이신 약들):

_____

해당되시는 것에 체크해 주세요.

Allergies to drugs (약에 의한 알레르기)		Asthma (천식)		Stroke (심장마비)	
Allergies to anesthetics (마취제에 의한 알레르기)		Hay fever (고열이나 알레르기)		Thyroid (갑상선에 의한 질환)	
Any heart ailments (심장질환)		Diabetes (당뇨)		Eye disorders (안구상의 질환)	
High blood pressure (고혈압)		Kidney problems (신장 문제)		Tonsillitis (편도선염)	
Cholesterol (콜레스테롤)		Liver problems or hepatitis (간염)		Tuberculosis (폐결핵)	
Neurological problems (신경성 질환)		Malignancies (암질환)		Ulcer or colitis (위계양 또는 대장염)	
Radiation treatments (방사선 치료)		Psychiatric care (정신질환)		Pregnancy If so, what month: (임신) 몇개월:	
Excessive bleeding from cut or extraction (과다 출혈)		Rheumatic fever (유머티즘열)		Anemia or blood problems (빈혈이나 동맥 결환)	
Sinus problems (비염)		Venereal disease (성병)		Arthritis (관절염)	
Immune System Disorders (AIDS, HIV, ARC) (에이즈)		Osteoporosis (골다공증)		Others (각종 다른 질환)	

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to *Christian Dental Arts* for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature (서명): _____ Date (날짜):_____/_____/_____