# McLean Smart Dental

**Patient Information & Health History**

## Patient Information (환자 정보)

| Patient's Name (성명) Last / First / M.I | Sex | Birth Date mm/dd/yy | Age |
|---|---|---|---|
| | M F | / / | |

| Soc. Security num. | Contact Number(연락처) | | E-MAIL |
|---|---|---|---|
| | Home | | |
| | Cell | | |
| | Work | | |

**Mailing Address (주소)**

| Street | Apt # | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

**How you like to receive reminders?(약속확인방법) via Phone / E-mail / 둘다**

**Reason for this Visit (방문이유)**

1. Cleaning and check up
2. Implant consult
3. Ortho consult
4. Pain(치아, 잇몸동통)
5. TMJ(악관절)
6. Others

☐ **I don't have Insurance**

## Dental Insurance Information (보험 가입자, 보험 정보)

| Policy holder's Name (보험 가입자 성함) | Policy holder's SSN or Policy Number(쇼셜 번호) |
|---|---|
| Policy holder's DOB (보험 가입자 생년월일) / /1 9 | Relationship to patient(환자와 가족 관계) |
| Insurance Company(보험이름) | Employer's name(보험 가입자 직장 이름) |
| Insurance Co. Address(보험회사주소) | Employer's address(보험가입자 직장 주소) |
| Group # | Local # |

## Responsible Party Information (환자가 18 세미만인 경우, 부모 또는 보호자)

| Name Last / First / M.I | Sex M F | Birth Date / / | Marital Status |
|---|---|---|---|
| | | | |

| Contact number H: / C : | E-MAIL | Relation to Patient(환자와 관계) |
|---|---|---|
| | | |

**Mailing Address(환자와 다른경우)**

| Street | Apt # | City | State | Zip |
|---|---|---|---|---|
| | | | | |

**Previous Dentist? (전 치과의)** **Name:** **City:** **State:** **Country:**

**Please RANK the following in the other in which they would KEEP YOU FROM having dental treatment. (1 to 4)**
**(치과방문이어려웠던 이유 순서대로 1-4)**

**Fear of pain(동통):** **LACK of concern(관심부족):** **COST of treatment(비용):** **MISSING work time(시간부족):**

**How do you know McLean Smart Dental? (어떻게 맥클린스마트치과를 아셨나요?)**

**AD(광고)** **WEB(인터넷)** **Friend (소개)** **others(기타)**

**It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.**

| DENTAL HISTORY | Yes | NO |
|---|---|---|
| Last COMPLETE Dental Exam, Date:?(마지막 치과검진) | | |
| Last X-RAYS, DATE: (마지막 x-ray 촬영) | | |
| Are you having any PROBLEMS now? (현재아프신가요) | | |
| What is it? (아픈부위) | | |
| Do you wear DENTURES? (부분 또는완전틀니) | | |
| Are you UNHAPPY with your dentures?(틀니가 불편한가요) | | |
| Have you had any GUM Treatments?(잇몸병 치료한 적이있나요) | | |
| Do your gums BLEED, or feel TENDER or IRRITATED? (잇몸에서피가나거나불편한가요) | | |
| Are you aware of GRINDING or CLENCHING your teeth?(이갈이습관 또는꽉무는습관이있나요) | | |
| Have you worn BRACES on your teeth (ORTHODONTICS)?(교정치료 받으시적이 있나요) | | |
| Do you REGULARLY use DENTAL FLOSS?(규칙적으로 치실을 사용하시나요) | | |

| MEDICAL HISTORY | | |
|---|---|---|
| Do you have any CURRENT HEALTH PROBLEMS?(어떤 전신질환이 있으신가요) | | |
| Are you under a PHYSICIAN'S CARE now? If yes for what? (치료받고 계신가요) | | |
| Have you ever taken anticoagulant or Aspirin? (아스피린이나 항응고제를 복용 하시나요) | | |
| What **MEDICATIONS** are you currently taking?(규칙적으로복용하는약이름들) | | |
| **Do you need to have premedication?(치료전 항생제를 복용해야 하시나요)** | | |
| Are you PREGNANT?(임신중이신가요) | | |
| Do you use cigarettes, pipe or chewing tobacco? (if yes, please CIRCLE)(담배피시나요)<br>If yes, How many per a day? 1-10 cigarettes 10-20 cigarettes >20cigarettes (>one pack) | | |
| **Are you allergic to or have you reacted adversely to any of the following medications?**? (if yes, please CIRCLE) **(다음중 알러지가 있는 것에 check 하세요)**<br>Antibiotics(항생제) Codeine(진통제) Latex(glove)(라텍스) Local anesthetics(치과용 국소마취제) base metal(비귀금속) others(기타) | | |
| **Is there any other medical or Dental information that you feel we should know about?(치료전 치과의사가 알아야하는 사항이있나요)** | | |
| Physician Name address. (주치의 이름, 주소) Name: Address: | | |

**Please Check 'Yes' or 'No' of the following which you have had, or presently have. (과거 또는현재 질환)**

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV pos.(에이즈) | | | Epilepsy(간질) | | | Psychiatric care(정신과 치료) | | |
| Anemia (빈혈 ) | | | Food allergies(음식 알레르기) | | | Rapid weight gain/loss(급작한 체중변화) | | |
| Arthritis (Rheumatism)(관절염) | | | Glaucoma(녹내장) | | | Radiation treatment(방사선 치료) | | |
| Artificial Heart Valves(인공 심장판막) | | | Headaches(두통) | | | Respiratory disease(호흡계 질환) | | |
| Artificial joints(인공관절) | | | Heart murmur(심장 잡 음) | | | Rheumatic/scarlet fever | | |
| Asthma(천식) | | | Heart Problems (describe) (심장질환을 열거하세요) | | | Shingles(대상포진) | | |
| Seasonal Allergies(계절성 알레르기) | | | Pacemaker/heart surgery/stent/others | | | Shortness of breath(짧은 숨) | | |
| Back Problems(척추 질환) | | | Hemophilia (Abnormal bleeding)(출혈) | | | Skin rash(피부 발진) | | |
| Blood disease(혈액 질환) | | | Herpes(헤르페스) | | | Spina bifida(이분 척추증 ) | | |
| Cancer(암) | | | Hepatitis(간염) | | | Stroke(뇌졸증) | | |
| Chemotherapy(화학치료) | | | High blood pressure 고혈압) | | | Surgical implant(메디칼 임플란트 이식) | | |
| Cortisone treatment(스테로이드 치료) | | | Jaw pain(턱관절 동통) | | | Swelling of feet or ankles(다리, 발목 부종) | | |
| Cough (persistent)(지속적 기침) | | | Kidney disease / malfunction(신장 질환) | | | Thyroid disease (갑상선 질환) | | |
| Diabetes(당뇨) Type I / Type II | | | Liver disease(간질환) | | | Tuberculosis(결핵) | | |
| | | | Nervous problems(신경계 질환) | | | Ulcer/Colitis(위궤양/장염) | | |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to McLean smart Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

**PATIENT Signature _____ DATE: / / DENTIST Signature _____**