DR. DAVID KIM, D.D.S.

161-14 Northern Blvd.
Flushing, NY 11358
Telephone: (718) 762-7006

PATIENT REGISTRATION AND MEDICAL HISTORY

Name(성함) ☐ Male ☐ Female			☐ Married ☐ Single ☐ Child ☐ Other_____
Social Security Number(소셜번호)			Date of Birth(생년월일) / /
Address(주소)			Apt
City		State	Zip
Telephone(전화번호)	Residence(집) ( )		Cell Phone(핸드폰) ( )
	Business(회사) ( )		Employer(직장)
Emergency Contact Number(응급시 연락처)		Name(성함)	Relationship
		Phone number(전화번호) ( )	
Referred or Recommended by(소개자)			
Reason for the visit(상담사유)			

DENTAL QUESTIONNAIRES

Date of last dental visit?(마지막 치과 방문 날짜)_____
Type of treatment done?(받으신 치료) _____
Have you ever experienced any complications related to dental treatment such as prolonged bleeding, fainting or muscle spasm etc.?
치과 치료시 피가 멎지 않았거나 혼절하신경우 혹은 근육경직 등의 경험이 있습니까? ☐ Yes ☐ No
Bleeding gum?(잇몸에서 피가 나십니까?) ☐ Yes ☐ No
Bad Breath?(입냄새가 나십니까?) ☐ Yes ☐ No
Grinding or clenching the teeth?(이를 갈거나 어금니를 꽉 깨무는 버릇?) ☐ Yes ☐ No
Sensitive to hot and cold? (차거나 뜨거운것에 민감함?) ☐ Yes ☐ No
Discomfort in front of ear when opening mouth?(입을 벌릴때 귀 앞 부위에 통증?) ☐ Yes ☐ No
Ulcer or any area of discomfort inside of mouth?(입안에 궤양이나 쓰린곳?) ☐ Yes ☐ No
Brushing(칫솔질) _____ times/day Dental Flossing(치실) _____ times/day

MEDICAL QUESTIONNAIRES

Physician's name(내과의사 성함) _____ Phone Number(전화번호)_____
Are you currently under physician's care?(현재 내과치료 중이십니까?) ☐ Yes ☐ No
If yes, reason(치료사유)_____
Date of last medical check up?(마지막 건강검진 날짜?) _____
Medication you are currently taking?(현재 복용하시는 약)_____
Please list all the medicine that you ever had adverse drug reaction to your body?(부작용 일으키는 약?)
_____
Please check all your present and/or past illnesses?(해당 질환에 표하십시오)
Hypertension(고혈압) ( ) Diabetes(당뇨) ( ) Heart Disease(심장질환) ( ) Thyroid Ds.(갑상선 질환) ( )
Liver Ds.(간 질환) ( ) Hepatitis(간염) ( ) Tuberculosis(결핵) ( ) Parathyroid Ds.(부갑상선) ( )
Anemia(빈혈) ( ) Asthma(천식) ( ) Kidney Disease(신장질환) ( ) HIV Positive(에이즈 감염) ( )
Cancer(암) ( ) Leukemia(백혈병)( ) Bleeding Ds.(혈액질환) ( ) Phychiatric Ds.(정신질환) ( )
Stroke(뇌졸중) ( ) Other?(그 외)_____
Smoking?(흡연) ___pack/day Drinking?(음주) moderate or heavy Pregnant?(임신) ___ months

To the best of my knowledge, the information provided on this form is complete and correct.
I understand that I am financially responsible for all fees and services rendered for treatment.

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

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INSURANCE

Primary Insurance	Dental Insurance(치과보험)		
	Medical Insurance(의료보험)		
☐ Self ☐ Spouse ☐ Parent	If other than self,	Subscriber's Name	
		Identification #	
		Date of Birth	
Secondary Insurance	Dental Insurance(치과보험)		
	Medical Insurance(의료보험)		
☐ Self ☐ Spouse ☐ Parent	If other than self,	Subscriber's Name	
		Identification #	
		Date of Birth	

I certify that I am/my dependents are covered by insurance with _____and assign directly to Dr. David Kim 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.

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