CONFIDENTIAL/CONFIDENCIAL
PLEASE COMPLETE FULLY/POR FAVOR LLENE TODOS LOD ESPACIOS
PLEASE PRINT/ESXRIBA EN LETRAS MAYUSCALAS

CHART NO.

1	☐ MR. ☐ MRS. ☐ MISS	LAST NAME OF PATIENT 성명	FIRST NAME	MIDDLE NAME	☐ SINGLE/독신 ☐ MARRIED/기혼 ☐ DIVORCED/이혼 ☐ WIDOWED/사별	TELEPHONE 전화
	HOME ADDRESS OF PATIENT 주소		CITY		ZIP	
	SOCIAL SECURITY NO. 쏘셜시큐리티번호	DRIVER'S LICENSE NO. 운전면허번호	OCCUPATION OF PATIENT 직업	BIRTHDATE 생년월일	AGE 나이	
2	RESPONSIBLE PARTY OR SPOUSE 배우자	RELATIONSHIP TO PATIENT 환자와의 관계	SOCIAL SECURITY NO. 쏘셜시큐리티번호	DRIVER'S LICENSE NO. 운전면허번호		
	ADDRESS 주소	CITY	ZIP	TELEPHONE 전화		
	EMPLOYER 직장	ADDRESS 주소	CITY	ZIP	TELEPHONE AT WORK 직장전화	

3

DO YOU OR ANY MEMBER OF YOUR FAMILY PARTICIPATE IN A DENTAL PLAN? ☐ YES ☐ NO
당신 또는 당신 가족이 덴탈보험에 가입하셨습니까?

EMPLOYEE'S NAME
직장이름 ____________

WHICH PLAN?
무슨보험입니까? ____________ GROUP NO. ____________

DATE EMPLOYED
취업일자 ____________

INSURED MEMBERS SOCIAL SECURITY NUMBER
보험자의 쏘셜시큐리티번호 ____________

LOCAL NUMBER
조합번호 ____________

NO. OF DEPENDANTS
가족수 ____________

DRIVER'S LICENSE NO.
운전면허번호 ____________

RELATIONSHIP TO PATIENT
환자와의 관계 ____________

4

HOW LONG SINCE YOUR LAST VISIT TO A DENTIST?
마지막 치과 가신게 언제입니까? ____________

REFERRED BY
소개자 ____________

WHY ARE YOU HERE TODAY?
무엇때문에 오셨습니까?

CHECKUP
진찰 ____________

TOOTHACHE
치통 ____________

ESTIMATE
경비견적 ____________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ____

Name of Insurance Company(ies)

and assign directly to Dr. ____________________________ all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorise the use of this signature on all my insurance submissions whether manual or electronic.

____________________ *Date* ____________________ *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of ____ do hereby request

Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

____________________ *Date* ____________________ *Signature of Insured / Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

____________________ *Date* ____________________ *Signature of Insured / Guardian*

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