\*모든 내용은 영문으로 작성해 주시기 바랍니다 \*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **이 름** | **이름 First 성 Last** | | | **날짜** | | | **방문날짜** | |  |
| **생년월일** | |  |
| **보호자 이름**  **(18세 미만일 경우)** |  | | | | | | | | |
| **혼인여부** | **미 혼 □ 기 혼 □ 기 타 □** | | | | **성별** | | | **남 □ 여 □** | |
| **주 소** |  | | | | | | | | |
| **도시, 주, 우편번호** |  | | | | | | | | |
| **전화번호** | **집** |  | | | | | **이메일** | |  |
| **휴대폰** |  | | | | |
| **근무처** |  | | | | | | **직함** | |  |
| **근무처 주소** |  | | | | | | | | |
| **비상 연락망** | **직계 가족 외에 비상시 연락 가능한 연락처를 작성해 주세요** | | | | | | | | |
| **이름** |  | | | | | **관 계** | | |  |
| **주 소** |  | | | | | **전화번호** | | |  |
| **치과 보험(Dental Insurance)이 있으신 경우, 아래 내용을 작성해 주시기 바랍니다.** | | | | | | | | | |
| **보험자 이름**  **Name of Primary Holder** |  | | **Social Security**  **Number** | | | | | |  |
| **보험 회사명**  **Insurance Company** |  | | **Member ID#** | | | | | |  |
| **Group #** | | | | | |  |
| **Referral** | **콜럼비아 치과를 어떻게 알게 되셨나요?**  **가족 혹은 지인 □ Yellow Pages □ 인터넷/홈페이지 □**  **보험회사 □ 신문/광고 □ 기타 □ ( )** | | | | | | | | |
| **위 내용은 본인의 정보와 일치함을 확인합니다.**  Release of Information / Assignment of Benefits  **서 명 Signature \_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **날 짜 Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*\*\* 예약 변경은 예약일로 부터 **48시간** 전까지 변경 가능합니다. 이를 지키지 못하실 경우, $50이 부과됩니다. \*\*\* | | | | | | | | | |
| **Medical History j0199755**  **모든 사항에 답변해 주시기 바랍니다.**  **답변하시는 모든 사항은 치료함에 앞서 필요한 정보입니다.**   1. 마지막 치과 방문이 언제이신가요? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    * 어떠한 치료를 받으셨나요? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. 교정을 하신 적이 있으신가요? **Yes □ No** □ 3. 잇몸 수술 (gum surgery) 을 받으신 적이 있으신가요? **Yes □ No** □ 4. 과거 치과 치료를 받으실 때 어려움이 있으셨나요? **Yes □ No** □ 5. 지난 3년간에 입원/수술 하신 적이 있으신가요? **Yes □ No** □    * **있으셨다면**, 어떠한 사유인가요? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. 지난 3년간에 지병을 앓으신 적이 있으신가요? **Yes** **□ No □**     * **있으셨다면**, 어떠한 사유인가요? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. 현재 받고 계신 치료가 있으신가요? **Yes □ No □**    * 치료 사유: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    * 담당의 이름: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    * 해당 병원 전화번호: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. 흡연을 하시나요? **Yes □ No** □ 9. 담배 외 다른 Tobacco를 사용하시나요? **Yes □ No** □   **현재 복용 중 이신 약이 있으시다면 아래 항목에 표시해 주세요.**   1. 페니실린/그 외 항생제 Penicillin/Other Antibiotics **Yes □ No** □ 2. 혈액 희석제 Blood Thinners **Yes □ No** □ 3. 스테로이드/코티손 Steroids/Cortisone **Yes □ No** □ 4. 고혈압약 High blood Pressure Medicine  **Yes □ No** □ 5. 진정제 Tranquilizer  **Yes □ No** □ 6. 면역 억제제 Immune Suppressant Drugs **Yes □ No** □ 7. 아스피린 Aspirin  **Yes □ No** □ 8. 허브/비타민 Herbs/ Vitamins  **Yes □ No** □   9) 그 외 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **알러지나 반응을 일으키는 항목에 표시해 주세요.**   1. 라텍스 Latex  **Yes □ No** □ 2. 국소 마취제 Local Anesthetics **Yes □ No** □ 3. 항생제/페니실린 Antibiotics/Penicillin  **Yes □ No** □ 4. 진정제/수면제 Sedative/Sleeping Pills **Yes □ No** □ 5. 코데인 Codeine/Other Narcotics  **Yes □ No** □ 6. 진통제Pain Medication **Yes □ No** □   약 이름/종류: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. 그 외 **Yes □ No** □   약 이름/종류: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

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| **다음 중 해당 되시는 사항에 표시 혹은 기재해 주세요.**   |  |  | | --- | --- | | **Cardiovascular** | **Infectious disease** | | **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  류마티스열 Rheumatic Fever 선천성 심장 결함  Congenital Heart Defect  울혈성 심부전  Congestive Heart Failure  심잡음 Heart Murmurs  심장 수술 Heart Surgery  고/저혈압 High/low blood pressure  뇌졸증 Stroke  그 외 심혈관 질환: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  간염 Hepatitis **Yes □ No □**  성병 Venereal Disease **Yes □ No □**  결핵 Tuberculosis **Yes □ No □**  HIV 양성 HIV Positive | | **Respiratory Disease** | | **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  천식/기관지염 Asthma/Bronchitis  폐기종 Emphysema  고초열 (꽃가루 알러지) Hay Fever | | **Endocrine Disorder** | **Blood Disorder** | | **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  당뇨 Diabetes  갑상선 기능 항진증 Hyperthyroidism  갑상선 기능 저하증 Hypothyroidism | **Yes □ No□**  빈혈 Anemia  상처가 날 경우 출혈이 심한 편이신가요?  Bleed excessively when cut?  **Yes □ No□** | | **Kidney Disease** | **Miscellaneous** | | **Yes □ No□**  **Yes □ No□**  신장염 경험이 있으신가요?  Kidney Infection  신장 수술을 하신 적이 있으신가요?  Kidney Surgery | **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  **Yes □ No□**  빈번한 기절 Frequent Fainting  간질환/황달 Liver Disease/ Jaundice  관절염 Arthritis  궤양 Ulcer  방사선 치료 Radiation therapy  항암 치료 Chemotherapy  그 외 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **위 항목 외에 건강상 문제가 있으신가요?** **Yes □ No** □  병명: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\*\*\* 여성분들만 답변해 주세요**  1) 현재 임신 중이신가요?  **Yes □ No** □  출산일 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2) 호르몬 치료 중이신가요?  **Yes □ No** □  **위 기재된 내용은 사실과 일치함을 확인합니다.**  **서명Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 날짜Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Columbia Dental Group & Georgia Dental Implant Center** 2476 Pleasant Hill Road Ste#201 Duluth GA 30096, 770-476-9116354 Bullsboro Drive Unit#4 Newnan GA 30263, 770-683-9622 5938 Buford Hwy #201/202 Doraville GA 30340, 770-559-5653  200 Ashford Center N. #330 Dunwoody GA 30338, 770-396-1188  **Written Financial Policy:** Thank you for choosing Columbia Dental Group & Georgia Dental Implant Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the nission is making the cost of optimal care as easy and manageable for out patients as possible by offeringseveral payment options.  **Payment options:** You can choose from:- Cash, Check, Visa, MasterCard, American Express or Discover Card- Convenient Monthly Payment Options1 from Care Credit Healthcare Credit Card  Columbia Dental Group & Georgia Dental Implant Center requires your co- payment at each of your appointments. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.  For plans requiring more than 1 appointment, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2000 or more, a 50% deposit is required to secure your initial treatment appointment.  For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.2  A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24- hour notice.  Columbia Dental Care & Georgia Dental Implant Center charges $35 for return checks.  If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.  **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient, Parent or Guardian Signature Patient Name Date**  1Subject to credit approval  2However, if we not receive payment form your insurance carrier within 90 days, you will be responsible for payment of your fees and collection of your benefits directly from your insurance carrier.  **Notice of Privacy Practices** 2476 Pleasant Hill Road Ste#201 Duluth GA 30096, 770-476-9116354 Bullsboro Drive Unit#4 Newnan GA 30263, 770-683-9622 5938 Buford Hwy #201/202 Doraville GA 30340, 770-559-5653  200 Ashford Center N. #330 Dunwoody GA 30338, 770-396-1188  **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.**  We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our practice. This notice describes how we protect your health information and what rights you have regarding it.  **TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**  The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up and appointment for you; examining your teeth; prescribing medications and faxing then to be filled; referring you to another doctor or clinic for other health care of services; or getting copies of your health information form another professional that you any have seen before us. Examples of how we use or disclose your health information for payment purposes are; asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts(either ourselves or through a collection agency or attorney). ‘Health care operations:” mean those administrative and managerial functions that we have to do in order to run out office. Examples of how we use or dissolve your health information for health care operations are : financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning ; and outside storage of out records.  We routinely use your health information inside out office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.  **USES AND DISCLOSURE FOROTHER REASONS WITHOUT PERMISSON**  In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.Such uses or disclosures are:When a state or federal law mandates that certain health information be reported for a specific purpose; For Public health purpose, such as contagious disease reporting, investigation or surveillance; and notices to and from federal Food and Drug Administration regarding drugs or medical devices;Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;Disclosures for judicial and administrative proceedings such as in response to subpoenas or order of courts or administrative agencies;Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;Disclosures to medical examiner to identify a deal person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;Uses or disclosures for health related research;Uses and disclosures to prevent a serious threat to health or safety;Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services; Disclosures of de-identified information; Disclosures relating to worker’s compensation programs; Disclosures of a ‘limited date set’: for research, public health or health care operations; Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; Disclosures to “business associates” who perform health care operations for us and who commit to respect of privacy of your health information. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.  **APPOINTMENT REMINDERS**  We may call or write to remind you of scheduled appointments, or that it is time to make routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and /or leave you a reminder message on your home answering machine or with someone who answer your phone if you are not home.  **OTHER USES AND DISCLOSURES**  We will not make any other uses or disclosures of your health information unless you sign a written “authorization form.” The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it’s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already aced in reliance upon it. Revocation must be in writing. Send them to the office contact person named at thebe ginning of this Notice.  Your rights regarding your health information  The law gives you many rights regarding your health information. You can: Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.  Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice. Ask to see or to get photocopies of your health information. By law, there are few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny you request, we will send you a written explanation, and instruction about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review o get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail show at the beginning of this notice.  Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the correct information to the person who we know got the wrong information, and others that specify. If we do not agree, you can write a statement of you position, and we will include it whit your health information along with any rebuttal statement that we may write. One you statement of position and/or our rebuttal is included in your health information; we will send it along whenever we make a permitted disclosure of your health information. By law we can have one 30 days extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E-mail show at the beginning of this Notice.  Get the list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include; disclosures with your authorization; incidental disclosure;  disclosures required by law; and health care operations, disclosures whit you authorization, incidental disclosure; disclosure required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of the time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E-mail show at the beginning of this Notice.  Get additional paper copies of this Notice of privacy practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E-mail show at the beginning of this Notice.  **OUR NOTICE OF PRIVACY PRACTICE** By law, we must abide by the terms of this Notice of privacy practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that already have as well as to such information that we may generate in the future. If we change our Notice of privacy practices, we will post the new notice in our office, have copies available in our office, and post it on our Wet side.  **COMPLAINTS** If thing that we have no properly respect the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, office for Civil rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail show at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.  **FOR MORE INFORMATION**  If you want more information about our privacy practices, call or visit the office contact person at the address or phone number show at the beginning of this Notice.  **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |