eng orthodontics
Dr. Albert Eng & Associates

Adult Health History

Patient Information

Today's Date__________

Patient's Name________________________________ Preferred Name/Nickname________________________

Address____

City____________________ State________ Zip__________ Cell______________________________

DOB ____/____/_____ Age________ Sex M F Employer ______________________________________

Language spoken ______________________ Email ____________________________________

Friends/Family seen in our office ____

Whom may we thank for referring you to our office? _______________________________________

Where have you seen Eng Orthodontics? (Please circle all that apply)

Dentist	TikTok	Facebook
Instagram	Google Review	Eng Ortho Website
Brighton Buzz Magazine	Reunion Living Magazine	SWAG (items with our logo on it)
King Soopers Shopping Cart (Bri/Reu)	School	Other ____________________

Medical History

Physician ____ Phone__________________________

Please Circle Yes or No (If yes, please specify)

Yes	No	Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?______________________
Yes	No	Are you taking any medications at this time? ______________________
Yes	No	Do you have any allergies to medication? ______________________
Yes	No	(If female) Are you pregnant? ______________________

Please circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Anemia	Herpes
Hepatitis/Liver problems	Pneumonia	Dizziness	Arthritis
Rheumatic Fever	GI disorders	HIV/AIDS	Tuberculosis
High blood pressure	Heart problems	Kidney problems	Epilepsy
Radiation/Chemo	Nervous disorders	Tumor or Cancer	Asthma or Hay fever
Congenital heart failure	Stroke	Latex or Nickel Sensitivity	

Any other medical conditions, sensory issues or other special needs that you feel we should be aware of

____

Dental History

Dentist ____ Phone __________________________

What concerns you about your teeth? ____

Do you have, or have you previously had any of the following?

Yes	No	Tongue Thrust	Yes	No	Jaw pain	Yes	No	Extra Adult teeth
Yes	No	Sore/Bleeding Gums	Yes	No	Tooth Sensitivity	Yes	No	Fear of Dental Work
Yes	No	Adult Tooth Extraction	Yes	No	Previous Orthodontic Treatment	Yes	No	Clenching or Grinding
Yes	No	Missing Adult Teeth	Yes	No	Clicking or Popping of Jaw	Yes	No	Finger or lip sucking habit
Yes	No	Difficult Chewing	Yes	No	Head/Neck, Jaw or Tooth injury	Yes	No	Chronic Mouth Breather

I acknowledge that the above information is correct and agree to inform the office of any changes that occur after this date. In addition, I authorize Dr. Albert Eng and Associates to perform a complete orthodontic evaluation.

Patient Name: ________________________________

Patient Signature: ________________________________ Date ______/________/________

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Authorization for Use and Disclosure of Protected Health Information

COMPLETE ONLY IF ENG ORTHODONTICS MAY SHARE PATIENT INFORMATION WITH OTHERS SUCH AS **STEPPARENTS, GRANDPARENTS, SPOUSE, FRIENDS**, ETC. IF THERE IS NO ONE YOU WOULD LIKE TO SHARE YOUR INFORMATION WITH, LEAVE BLANK AND SIGN BOTTOM LINE.

Patient Last Name ______________________________ First Name ______________________________________

Patient's DOB ______/_______/________ Address____

I, (name of patient or legal guardian if patient is under 18 years of age) ______________________, hereby authorize Eng Orthodontics to release information, as indicated below, to the following person(s) listed below.

Check the information to be released:

Name	Relationship	Phone	Any	Clinical	Financial

I authorize Eng Orthodontics to contact the individual(s) listed above to convey information as listed above regarding the patient in the event that I am unable to be reached by Eng Orthodontics.

I understand that I may revoke/cancel this authorization by notifying Eng Orthodontics, in writing, of my intent to revoke authorization, or change the name(s) of those listed to whom the information is to be released.

Please note that if the patient is under the age of 18, a legal guardian must either be present during the initial consultation or must have this page filled out with the name of the individual(s) bringing the patient to the exam.

____ ____________________________

Signature of patient
(OR legal guardian if the patient is under 18 years of age)

Date

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Dental Insurance Information

Insurance Company Name ______________________________

Insurance Company Address ______________________________ Phone ______________

Employer Name ______________________________

Group No. ______________________________ Subscriber ID No. ______________

Policy Holder Name ______________________________

Policy Holder SSN ________-_______-________ Policy DOB ______/______/______

(If you have dual coverage, please complete information below)

Insurance Company Name ______________________________

Insurance Company Address ______________________________ Phone ______________

Employer Name ______________________________

Group No. ______________________________ Subscriber ID No. ______________

Policy Holder Name ______________________________

Policy Holder SSN ________-_______-________ Policy DOB ______/______/______

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Master Card, Visa and Discover. Returned checks and balances older than 30 days may be subject to additional collection fees of $30 per month. We will gladly assist you by submitting all insurance claims pertaining to charges for care rendered in our office. It is your responsibility to make sure we have the most current and up to date insurance information including any secondary insurance policies.

We must emphasize that as a dental care provider, our relationship is with our patients and their families and not with their respective insurance companies. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Signature: ______________________________ Date ______/______/______