eng orthodontics
Dr. Albert Eng & Associates

# Child Health History

## Patient Information

Today's Date____________

Patient's Name______________________________ Preferred Name/Nickname______________________

Address____________________________________________________________

City______________________ State__________ Zip__________ Phone____________________

DOB ____/_____/______ Age__________ Sex M F School ______________________

## Parent/Guardian Information

Patient lives with: Both Parents Mother Father Other: ____________________

Guardian 1 ______________________________ Relationship to Patient ____________________

Employer ______________________________ Cell # ____________________

Guardian 2 ______________________________ Relationship to Patient ____________________

Employer ______________________________ Cell # ____________________

Address (if different from patient) ______________________________________

City__________________ State__________ Zip__________ Email ____________________

Language spoken ____________________

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
Instagram
Brighton Buzz Magazine
King Soopers Shopping Cart (Bri/Reu)

TikTok
Google Review
Reunion Living Magazine
School

Facebook
Eng Ortho Website
SWAG (items with our logo on it)
Other ____________________

## Medical History

Physician ______________________________ Phone____________________

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

Yes No Does this patient now or have they ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?____________________

Yes No Is the patient taking any medications at this time? ____________________

Yes No Does the patient have any allergies to medication? ____________________

Yes No (If female) has the patient begun menstruation? What age?____________________

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
Hepatitis/Liver problems
Rheumatic Fever
High blood pressure
Radiation/Chemo
Congenital heart failure

Diabetes
Pneumonia
GI disorders
Heart problems
Nervous disorders
Stroke

Anemia
Dizziness
HIV/AIDS
Kidney problems
Tumor or Cancer
Latex or Nickel Sensitivity

Herpes
Arthritis
Tuberculosis
Epilepsy
Asthma or Hay fever

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 child's teeth? ______________________________

Does your child have, or have they 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.

Guardian Name: ______________________________ Relationship to Patient:____________________

Guardian Signature: ______________________________ Date ________/__________/__________

eng orthodontics
Dr. Albert Eng & Associates

# 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

eng orthodontics
Dr. Albert Eng & Associates

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 _____/________/_______