ADULT MEDICAL HISTORY

Patient's Name ______________________________ Date______________________________

Dentist's Name ______________________________ Date of Last Dental Exam ______________________

Physician's Name______________________________ Date of Last Physical Exam______________________

Now or in the past, has the patient had (Please Circle):

Y __ N __ Adenoids or tonsils removed
Y __ N __ Arteriosclerosis (hardening of the arteries)
Y __ N __ Asthma, hay fever, sinus trouble or hives
Y __ N __ Autoimmune disorders or immune system problems
Y __ N __ Bleeding or bruising easily
Y __ N __ High or low blood pressure – please circle
Y __ N __ Cancer, tumor, chemotherapy or radiation treatment
Y __ N __ Chronic fatigue
Y __ N __ Current pregnancy
Y __ N __ Depression or other mental health disturbance
Y __ N __ Diabetes
Y __ N __ Dizziness
Y __ N __ Epilepsy or other seizure disorder
Y __ N __ Fibromyalgia
Y __ N __ General anesthesia
Y __ N __ Hearing impairment
Y __ N __ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y __ N __ Frequent coughs, colds or sore throats
Y __ N __ Hemophilia
Y __ N __ Hepatitis, AIDS or HIV positive
Y __ N __ Injury to face, neck, mouth or teeth – please circle
Y __ N __ Insomnia
Y __ N __ Jaw joint surgery
Y __ N __ Kidney or liver problems
Y __ N __ Meniere's disease
Y __ N __ Multiple sclerosis
Y __ N __ Muscular dystrophy
Y __ N __ Nighttime breathing problems (snoring or sleep apnea)
Y __ N __ Nervousness
Y __ N __ Neuralgia
Y __ N __ Osteoarthritis (stiff or swollen joints)
Y __ N __ Osteoporosis
Y __ N __ Parkinson's disease
Y __ N __ Prior orthodontic treatment
Y __ N __ Psychiatric care
Y __ N __ Rheumatic fever
Y __ N __ Rheumatoid arthritis
Y __ N __ Scarlet fever
Y __ N __ Skin disorder
Y __ N __ Speech difficulties
Y __ N __ Stroke or heart attack
Y __ N __ Tuberculosis
Y __ N __ Wisdom teeth extraction
Y __ N __ Birth defects or hereditary problems
Y __ N __ Endocrine or thyroid problems
Y __ N __ Stomach ulcer or hyperacidity
Y __ N __ Polio, mononucleosis or pneumonia
Y __ N __ Vision problems
Y __ N __ Loss of weight recently, poor appetite
Y __ N __ Eating disorder (anorexia or bulimia)
Y __ N __ Chest pain, shortness of breath or swelling ankles
Y __ N __ Frequent or severe headaches
Y __ N __ Other condition

Allergies or reactions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotics
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other

Medications:
Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Emergency Contact ______________________ Relationship ____________ Phone #____________

Patient/Parent Signature __________________________ Today's Date____________________

WELCOME TO OUR OFFICE!

ADULT PATIENT FORM

Today's Date: ______/_____/_______

Patient Name: ____ Birth Date: ___________ Gender: __________

Greeting (Preferred Name) : ______________________________________ Marital Status/Spouse's Name:________________

Mailing Address: ____

City: _______________________________ Zip: ____________ Email: ____

Home Phone: ____________________________________ Work Phone: ____

Cell Phone: ____________________________________ Cell Phone Carrier: ____

Employer: ______________________________________ Occupation: ____

Referred By: ____________________________________ General Dentist: ____

Past or Present Family Members in Treatment: ____

Have you Consulted an Orthodontist Before: ____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Subscriber Name: _________________________________

Insurance Co. Name: _______________________________

Group Plan/Employer's Name: ________________________

Group #: ____

Insured ID #: _____________________________________

Ins. Co. Address: __________________________________

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Ins. Co. Phone #: __________________________________

SECONDARY DENTAL INSURANCE

Subscriber Name: _____________________________________

Insurance Co. Name: ___________________________________

Group Plan/Employer's Name: ____________________________

Group #: ____

Insured ID #: ____

Ins. Co. Address: ______________________________________

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Ins. Co. Phone #: ______________________________________

As a courtesy, we accept assignment of benefits from your insurance carrier. As we deal with insurance on your behalf, carriers require that we keep your signature on file. Please sign the statements below such that we may offer this service.

I have reviewed the treatment plan(s) and I authorize the release of any information relating to the claim(s).
I hereby authorize direct payment to Dr. Michael Choy & Dr. Russell Choy / Choy Ortho-Pedo, PLLC of the group insurance benefits otherwise payable to me.

____
Signature of insured parent / guardian

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF HEALTH PLAN DOCUMENTS

In considering the amount of healthcare expenses to be incurred, I, the undersigned, have insurance and / or employee dental care benefits coverage with the above captioned, and hereby assign and convey directly to OPD Smiles Orthodontics & Pediatric Dentistry all dental care benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctors and practice. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctors to release all information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health and dental benefits claim submissions. I hereby convey to the above named doctors and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health and dental care plan with respect to medical expenses incurred as a result of the services I received from the above named doctors and practice and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctors and practice in any attempts by such doctors and practice to pursue such claim, chose in action or right against my insurers and/or employee health and dental care plan, including, if necessary, bring suit with such doctors and practice against such insurers and/or employee health and dental care plan in my name but at such doctors and practice's expenses. This assignment will remain in effect for seven years or until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I have read your authorization and legal assignment of benefits and agree to its terms. My signature authorizes you to disclose my PHI in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

By signing below you acknowledge and accept legal assignment of benefits.

______________________________	________________________	__________
Signature of insured parent / guardian	Relationship to patient	Date