CHILD HEALTH HISTORY

Patient Name:_____ Date: _____

Pediatrician's Name:_____Pediatrician's Phone:_____Last Check – Up: _____

Please Mark Appropriate Answer (Leave blank if don't understand the question)

☐YES ☐NO Is your child in good health?

☐YES ☐NO Is your child up to date with vaccines?

☐YES ☐NO Was your child born prematurely? If yes, how many weeks? _____

☐YES ☐NO Has your child been hospitalized or had surgery? If yes, explain: _____

☐YES ☐NO Is your child currently taking any medications? If yes, please list: _____

☐YES ☐NO Does your child have any allergies to any medications, food, materials or other?

If yes, please list: _____

Has your child ever had the following medical problems?

☐ ADD	☐ Cerebral Palsy	☐ Nervous Disorder	☐ Rheumatic Fever
☐ ADHD	☐ Diabetes	☐ HIV	☐ Seasonal Allergy
☐ AIDS	☐ Downs Syndrome	☐ Kidney Problem	☐ Seizure
☐ Asthma	☐ Emotional Disorder	☐ Liver Problem	☐ Sickle Cell Anemia
☐ Autism	☐ Epilepsy	☐ Leukemia	☐ Speech Disorder
☐ Blood Disorder	☐ Hearing Disorder	☐ Mental Disorder	☐ Tuberculosis
☐ Brain Disorder	☐ Heart Condition	☐ Physical Disability	☐ Vision Disorder
☐ Cancer	☐ Hepatitis	☐ Respiratory Problem	☐ Other _____

☐YES ☐NO Has your child ever need pre-medication for dental work? If yes, a signed form from the child's cardiologist will be required explaining condition and amount of medication needed before any dental treatment will be rendered.

Reason your child is here today: _____

☐YES ☐NO Is your child having a toothache?

☐YES ☐NO Is this your child's first dental visit?

☐YES ☐NO Does or did your child use a bottle, pacifier, or sippy cup? If yes, when stopped: _____

☐YES ☐NO Does your child currently or in the past have a habit of finger sucking or lip/nail biting? If stopped, when: _____

☐YES ☐NO Any history of trauma to the teeth or jaws? If yes, explain_____

☐YES ☐NO Any unhappy medical or dental experiences If yes, explain_____

Previous Dentist: _____ Date of last visit: _____ Cleaning Done? ☐YES ☐NO

Any X-Rays taken? ☐YES ☐NO

Is there any additional information that may help us in caring for your child or any specific concerns you have regarding your child's dental health? _____

EMERGENCY CONTACT

Name: _____

Phone:_____Relationship to patient: _____

To the best of my knowledge, I have answered every question completely and accurately. I understand that it will be held on the strictest of confidence, and it is ***my responsibility*** to inform the office of any changes in my child's medical status.

Name of Parent / Guardian:_____Date: _____

Signature of Parent / Guardian: _____

Relationship to Patient:_____Name of Patient: _____

WELCOME TO OUR OFFICE!

CHILD PATIENT FORM

Today's Date: _____/_____/_____

Patient Name: _____ Birth Date: _____/_____/_____

Greeting (Preferred Name) : _____

Patient lives with: □ Both parents □ Mother □Father Other: _____

Mother's Name: _____
FIRST MIDDLE LAST

Street Address_____

City: _____ Zip: _____

Social Security #: _____ D.O.B.: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone Carrier: _____

Employer: _____

Employer Address: _____

_____

Email: _____

Father's Name: _____
FIRST MIDDLE LAST

Street Address: _____

City: _____ Zip: _____

Social Security #: _____ D.O.B.:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone Carrier: _____

Employer: _____

Employer Address: _____

_____

Email: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Subscriber Name: _____

Insurance Co. Name: _____

Group Plan/Employer's Name: _____

Group #: _____

Insured ID #: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone #: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____

Insurance Co. Name: _____

Group Plan/Employer's Name: _____

Group #: _____

Insured ID #: _____

Ins. Co. Address: _____

_____

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