Christensen Orthodontics

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information- Child or Teen

First Name: _____ *Last Name:* _____ *Middle Name:* _____
Age: _____ *Date of Birth:* _____ *Nickname:* _____ *Male or Female:* _____
Home Address: _____ *City:* _____ *State:* _____ *Zip:*_____
Phone Number: _____ *Email Address:* _____
Who is with patient today? _____ *Relationship to patient:* _____
Patient's general dentist: _____ *Who may we thank for referring you to our office?* _____
Have we treated another member of the family? _____*Name*_____
Has your child visited an orthodontist before? _____ *If YES for what reason?* _____
What are the main concerns that you would like orthodontics to accomplish? _____
Anything you would like to discuss with the doctor in private? _____

Parents Information

Father

Marital Status: Single Married Widowed Divorced Separated Domestic Partner
Father Step Father Guardian First Name: _____*Last Name:* _____*Middle Name:* _____
Date of Birth: _____ *Social Security #:*_____*Cell Phone:* _____*Home Phone:* _____
Address: _____*City:* _____*State:* _____ *Zip:* _____
Employer: _____ *Employer's Number:* _____

Mother

Marital Status: Single Married Widowed Divorced Separated Domestic Partner
Mother Step Mother Guardian First Name: _____*Last Name:* _____*Middle Name:* _____
Date of Birth: _____*Social Security #:* _____ *Cell Phone:* _____*Home Phone:* _____
Address: _____ *City:* _____ *State:* _____ *Zip:* _____
Employer: _____ *Employers Number:* _____

Dental Insurance (Must be filled out completely in order for us to verify benefits)

Primary Insurance Company: _____*Address:* _____ *Phone:* _____
Subscriber Name: _____*Date of birth:* _____ *Social Security #:*_____
Subscriber Address: _____*ID #:* _____*Group #:* _____

Secondary Insurance Company: _____*Address:* _____ *Phone:* _____
Subscriber Name: _____ *Date of Birth:* _____ *Social Security #:* _____
Subscriber Address: _____*ID #:* _____ *Group #:*_____

Additional Dental Coverage

Insurance Company: _____*Address:* _____*Phone:* _____
Subscriber Name: _____ *Date of Birth:* _____*Social Security #:* _____

Subscriber Address: _____ID #: _____ Group #:_____

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Troy Christensen, DDS, MS
Specialist in Orthodontics

Medical History

Is the child currently under care of a physician? _____ If Yes, for what reason? _____
Child's Physician's Name: _____ Phone #: _____
Does your child have any history of major illnesses? _____ If Yes, Please describe: _____
List any allergy or drug sensitivity that your child has: _____
Currently taking any medications? _____ If Yes, please list: _____
Has your child reached puberty? _____
Has your child been treated for any of the following?

□ *Arthritis* □ *Asthma* □ *Blood Disorder* □ *Cancer* □ *Diabetes* □ *Epilepsy* □ *Heart Condition*
□ *Nervous Disorder* □ *Tuberculosis* □ *Other* _____

Dental History

Does your child require antibiotics before dental treatment? _____ If Yes, please explain: _____
Has your child tonsils/adenoids been removed? _____ If Yes, What age? _____
Have you been informed that your child is missing any permanent teeth? _____
Have you been informed that your child has any extra permanent teeth? _____
Has your child had any injuries to their face, mouth or chin? _____ If Yes, Please explain: _____
Has your child ever complained of pain/tenderness in the jaw joint (TMJ/TMD)? _____
Does/Did your child have any of the following habits?

□ *Grinding Teeth* □ *Finger/Thumb Sucking* □ *Prolonged Bottle/ Pacifier* □ *Mouth Breather*
□ *Speech Problems* □ *Chewing/Eating Problems* □ *Other* _____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits to this office.

Signature: _____ Date: _____