CHILD HEALTH HISTORY FORM

Today's Date: _____/_____/_____

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

YOUR CHILD

Patient ID#_____

Child's Name_____
Last First

Male: _____ Female: _____

Date of Birth: _____/_____/_____ Age: _____

Child's Mailing Address: _____

Child's Physical Address: _____

City_____ State_____ Zip_____

Who may we thank for referring you to our office.

_____

MOTHER ☐ Stepmother ☐ Guardian

Marital Status: ___ Single ___Married ___Divorced ___Widow ___Seperated

Name: _____
Last First

Mailing Address: _____

Physical Address: _____

City_____ State_____ Zip_____

How Long at this address?:_____

Email: _____

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____/_____/_____

Home Phone Number: _____/_____/_____

Cell Phone Number: _____/_____/_____

Employer:_____

How Long with this employer?:_____

FATHER ☐ Stepfather ☐ Guardian

Marital Status: ___ Single ___Married ___Divorced ___Widow ___Seperated

Name: _____
Last First

Mailing Address: _____

Physical Address: _____

City_____ State_____ Zip_____

How Long at this address?:_____

Email: _____

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____/_____/_____

Home Phone Number: _____/_____/_____

Cell Phone Number: _____/_____/_____

Employer:_____

How Long with this employer?:_____

☐ **PLEASE CHECK IF THERE IS NO INSURANCE**

PRIMARY DENTAL INSURANCE

Insured Name: _____

Relationship to patient: _____

Insured Date of birth: _____/_____/_____

Social Security Number:_____/_____/_____

Employer:_____

Group #: _____ ID#: _____

Insurance Company: _____

Ins. Phone Number: _____

SECONDARY DENTAL INSURANCE

Insured Name: _____

Relationship to patient: _____

Insured Date of birth: _____/_____/_____

Social Security Number: _____/_____/_____

Employer:_____

Group #: _____ ID#: _____

Insurance Company: _____

Ins. Phone Number: _____

*****PLEASE COMPLETE BOTH SIDES*****

DENTAL HISTORY *CONFIDENTIAL*

Current Dentist: _____ Date of last visit: _____

How often does your child brush? _____ How often does your child floss? _____

Has your child experienced problems with past dental work? YES _____ NO _____

Has your child ever been evaluated for orthodontics? YES _____ NO _____

Has there been any injury to the face, mouth or teeth? YES _____ NO _____

Does your child have any of the following habits?

- ☐ Lip sucking/biting
- ☐ Clenching/Grinding Teeth
- ☐ Used pacifier
- ☐ Speech Problems
- ☐ Nail Biting
- ☐ Thumb/Finger sucking
- ☐ Tongue Thrust
- ☐ Chewing on objects
- ☐ Tongue/Cheek Biting
- ☐ Mouth breather

MEDICAL HISTORY

Child's Physician: _____ Phone #_____ Date of last visit: _____

Is your child currently under the care of a physician? YES _____ NO _____

Please explain: _____

Describe your childs current physical health: ___Good ___Fair ___Poor

Please list any medications that your child is currently taking: _____

Is your child allergic to any of the following? (Please Circle)

Codeine Penicillin Sulfa Anesthetics Metals/Plastics Latex

Please list any other allergies/sensitivites/adverse reactions they may have: _____

_____

Has your child ever had any of the following:

- ☐ Abnormal Bleeding
- ☐ AIDS/HIV+
- ☐ Anemia
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Convulsions
- ☐ Fainting
- ☐ Hearing Impairment
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hives/Rash
- ☐ Hospital Stay/operations
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Measles
- ☐ Mitral valve Prolapse
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Severe Headaches
- ☐ Tonsilitis
- ☐ Tuburculosis(TB)

Please list any other serious medical conditions/problems your child may have: _____

_____

By signing below, I acknowledge that I have read and received the Notice of Privacy Practives, as mandated by the Heath Insurance Portability and Accountability Act of 1996 ('HIPPA')

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I also authorize this office to perform necessary dental services I may need.

Signature of responsible Party _____ Date _____/_____/_____

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

CHILD SLEEP, BREATHING & HABIT QUESTIONNAIRE

Today's Date _____/_____/_____

Patient's Name _____ Birthday _____/_____/_____ Age_____

Medical issues: _____ Medications taking: _____

Previous clip or release of tongue? _____ (Date)_____

Has your child experienced any of the following issues? Please check all that apply or elaborate as needed.

Sleep Issues (Check all that apply)

___ Difficulty Falling Asleep
___ Difficulty Staying Asleep
___ Snoring
___ Interrupted snoring, where breathing stops
___ Labored, difficult or loud breathing at night
___ Gasping for air while sleeping
___ Mouth breathing during the day
___ Mouth breathing while sleeping
___ Dry mouth upon awakening
___ Teeth grinding/clenching while sleeping
___ Moves around a lot at night (kicks)
___ Feel sleepy and/or irritable during the day
___ Wakes up easily or often
___ Excessive sweating while sleeping
___ Talking in their sleep
___ Wets the bed currently
___ History of bed wetting
___ Headaches/Migraines
___ Frequent throat infections
___ Ear Infections (Past / Present)
___ Allergy Symptoms
___ Acting out dreams
___ Hard to wake up in the mornings

Speech:

___ Frustration with communication
___ Difficult to understand by others
___ Difficulty speaking fast
___ Difficulty getting words out (groping for words)
___ Trouble with sounds (which?)_____
___ Speech delay (when?)_____
___ Stuttering
___ Nasal Speech
___ Speech therapy (how long)_____
___ Mumbling or speaking softly
___"Baby Talk"
___ Swallowing problems with liquids and/or solids?

Other related issues:

___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Strong gag reflex
___ Tonsils or adenoids removed previously
___ Ear tubes previously
___ Reflux (medicated or not)
___ Hyperactivity / Inattention
___ Trouble Focusing
___ Difficulty Listening/Often Interrupts
___ ADD/ADHD
___ Sensory Issues
___ Struggles in Math or Reading at school

Feeding:

___ Frustration when eating
___ Slow Eater (don't finish meals)
___ Graze on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky with textures
___ Choking or gagging on food
___ Spits out food
___ Refuses to try new foods
___ Other:

Nursing or Bottle-Feeding Issues as a Baby

___ Painful nursing or shallow latch
___ Poor weight gain
___ Reflux or spitting up
___ Unable to hold pacifier
___ Milk dribbled out of mouth / messy eater
___ Poor Supply
___ Nipple shield required for nursing
___ Clicking or smacking noise when eating
___ Cried a lot / colic as baby

INSURANCE AGREEMENT
"ACCEPTING" ASSIGNMENT OF BENEFITS

Thank you for choosing the office of Dr. Bret B. Christensen to provide for your orthodontic needs. As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to orthodontic coverage. We permit you to use your orthodontic benefit to lower your portion of the cost of orthodontic treatment, rather than paying the full fee up front and waiting for reimbursement from the insurance company. This allows you the financial freedom of paying only your part of the treatment fee, while we accept ourselves to be very vulnerable to the insurance company; therefore, we have set some guidelines and limitations, which much be recognized and adhered to.

PECULIARITIES:

First, it is critical to understand that the term "dental/orthodontic insurance" is misleading. What is commonly known as "dental/orthodontic insurance" is more correctly termed "dental/orthodontic benefits." Orthodontic benefits are not intended to pay everything; rather, they assist with the costs of orthodontic treatment. Your dental insurance is based upon a contract between you and/or your employer and the insurance company. *Our practice is in no way associated with the contract between you and your insurance company. Therefore, we are not responsible for the terms or benefits of your insurance*

CHANGE IN BENEFITS, ELIGIBILITY OR CARRIER:

- At any point in treatment, if you change jobs or become ineligible for orthodontic benefits, you must notify us immediately. After that we will average any remaining benefits originally anticipated into your monthly payments.
- At any point in treatment, if your employer changes insurance carriers, you must notify us immediately. If the new policy has orthodontic benefits, you must forward a new form to us so that we may file a claim with the new carrier. If the new policy does not have orthodontic benefits, we will average any remaining benefits originally anticipated into your monthly payments.

INTENTIONAL OR UNINTENTIONAL WITHHOLDING OF BENEFITS:

When benefits are assigned directly to this office, if the insurance company sends a check to you in error, we will hold you responsible for immediate and complete reimbursement. Should you receive a check from your insurance company in error, mail or bring it into the office. DO NOT deposit or cash it. Any attempt to withhold insurance funds received by you in error will result in an immediate termination of this insurance agreement and we will hold you directly responsible for the balance of the payments due.

MISCELLANEOUS:

- All insurance benefits are payable to the dental office, and I agree to release any information necessary for the orthodontic office to process claims.
- At the conclusion of treatment, if the insurance company has not paid the entire benefit available, we will hold you directly responsible for payment of the entire account before the orthodontic appliances are removed.
- At any point during treatment, if the insurance company becomes uncooperative, we reserve the right to refuse to work with that insurance and will look to you for payment of the remaining balance and you will have to settle with your insurance company.
- In the case of divorced or separated parents, if the insurance company issues a payment to the non-custodial parent, the custodial parent will become responsible for immediate and complete reimbursement of that amount to this office.

I understand the contents of this orthodontic insurance agreement, and I agree to honor them. Furthermore, I understand that your office can only estimate my orthodontic benefit. I will take responsibility for the balance on my account. In the event that I default on this account I understand that it will be turned over to collections. I authorize this office to file claims on my behalf. I give permission for benefits to be paid directly to Dr. Christensen.

_____

Responsible Party Printed Name

_____

Responsible Party Signature

_____

Date

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

CHRISTENSEN ORTHODONTICS
INFORMED CONSENT

The purpose of this memorandum is to inform the patient and/or parents of the course of events that they may expect during orthodontic treatment. It emphasizes the need for patient cooperation and points out the risks and limitations of orthodontic treatment. You are encouraged to read the following information, ask any questions that come to mind, and then consent to our treatment by initialing and signing this form. This is standard procedure in our practice.

1. TYPICAL ORTHODONTIC TREATMENT

_____ORTHODONTIC RECORDS

I hereby authorize Christensen Orthodontics to edit, copy, exhibit, publish and distribute any photo for purposes of publicizing or for any other lawful purpose, including the use of the photographs on the Christensen Orthodontics Facebook page or other social media sites. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein any likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photographs.

_____TREATMENT TIME

Orthodontics with full braces generally takes anywhere from one to two years. The insufficient wearing of elastics, removable appliances and headgear, broken appliances, poor patient cooperation, and missed appointments will result in extension of treatment and a compromise in the final result. If for any reason treatment is completed before the estimated time, the treatment plan fee does not change.

_____APPOINTMENTS

Depending on the stage of treatment, you may be required to visit the orthodontist every 8 weeks or as frequently as 3 times a month. Some appointments may require as little as 5 minutes, while others can be 2 hours or more. Your treatment will require a great amount of cooperation to accomplish treatment goals in the time prescribed.

_____RETENTION

After braces have been removed, you will be provided with clear, temporary retainers and either a fixed or removable retainer. Fixed retainers can require periodic maintenance which could include a charge. Removable retainers will be worn full time for the first year and then night time thereafter to ensure that the teeth hold and settle into their position. Failure to wear the retainers as prescribed may result in a partial relapse of the malocclusion and could result in the need for interventional treatment not included in original treatment estimate and cost.

MAILING RETAINERS: Should we need to mail you any of the clear trays, there will be a **$10 shipping fee.**

_____EXTRA COSTS/FEE's

DO NOT REMOVE any broken or loose appliances or fixed retainers. If for any reason any appliance or fixed retainer comes loose, contact the office immediately for an appointment. Removal of the appliance or fixed retainer can result in an additional charge. Fixed retainers are guaranteed for 12 months after the placement. If for any reason it comes loose or off after those 12 months, there is an **$92 REBOND CHARGE**, or possibly a replacement fee due at the time of service.

AFTER HOURS FEE: Should you need to be seen after regular office hours, there will be a **$92 FEE** due when the patient is seen.

NO SHOW FEE: Time is valuable for everyone. Please arrive on time for your appointment so we can ensure that all patients are in and out in a timely manner. If you are more than 10 minutes late for your appointment, you will be placed on stand-by, or asked to reschedule.
If you no-show your appointment, you will be charged a **$25 NO SHOW** fee. We require at least 24 hours' notice if you cannot make the appointment. Your first offense we will waive the fee as a courtesy. Your second offense will result in the $25 no show fee and payment will be required prior to the next visit. Your third offense will result in review of your account and you may be subject to possible non-treatment.

2. WHAT YOU CAN EXPECT DURING TREATMENT

_____DISCOMFORT

Orthodontics requires the use of wires to apply gentle pressure on the teeth in order to move them. When the pressure is applied, a tenderness of the teeth results. The teeth will remain sore for a period ranging from one to five days. The intensity and duration of the discomfort varies with each patient. If the pain is intolerable, possibly altering the method of straightening the teeth can decrease the discomfort.

_____ELASTICS

Elastics are used to help the orthodontist apply addition pressure to the teeth when needed. It is the patients' responsibility to follow the orthodontists' instructions regarding the use and wearing of elastics.

_____COOPERATION IS ESSENTIAL

Successful treatment can only be obtained with a team effort. In order to complete treatment, with the best results, and in the amount of time on your treatment plan, the patient must do the following:

- Keep appointments
- Practice good oral hygiene; clean your teeth and appliances after each meal.
- Wear elastics (rubber bands) as instructed.
- Inform office immediately of any broken, loose or lost appliances

FAILURE TO FOLLOW THE GUIDELINES, INCLUDING ANY INSTRUCTIONS FROM THE DOCTOR AT THIS PRACTICE, COULD RESULT IN ADDITIONAL COSTS.

_____EATING HABITS

You should not eat any hard, sticky or chewy foods, as these will tend to break or loosen your appliances. Apples, carrots and other hard foods must be cut up into bite-size pieces before eating. Chewing ice is prohibited. Your appliances can easily be broken if the above is not adhered to at all times.

____REMOVAL OF TEETH

No one likes to have teeth removed, but sometimes it is necessary in order to obtain the most desirable results. Having teeth pulled will be recommended as part of the treatment if it is determined that doing so will enhance the stability, esthetics and function of the final result.

_____GINGIVAL SURGERY

Gingival (gums) surgery may be required in order to place bands or brackets in the proper positions, to reduce tendency of relapse of severely rotated teeth, or to attach gingival, and for esthetic reasons. Should any of these procedures be indicated, it will discussed during the course of treatment.

_____FRENULOPLASTY SURGERY

A frenectomy may be diagnosed and recommended during or after orthodontic treatment. Frenectomy is a procedure to correct a congenital condition when the lingual (tongue) or labial (lip) frenulum is tight, resulting in restriction of function. If this procedure is needed further discussion will occur.

_____**ORAL SURGERY**

Some of the malocclusions are so severe that orthodontics alone cannot obtain adequate results; therefore, jaw surgery may be required in order to achieve acceptable and stable results. Should surgery be indicated, further discussion will occur.

3. POTENTIAL RISKS AND LIMITATIONS OF TREATMENT

_____**DECALCIFICATION/DISCOLORATION**

Orthodontic appliances do not cause tooth decay, but because of their presence, food particles are more readily retained and the potential for tooth decay is greatly increased. The reduction of sugar intake and reporting any loose bands will help minimize decay and gum problems. Patients should carry a toothbrush and clean their teeth and appliances after every meal. The permanent white lines that are seen on some teeth after braces are removed are called decalcification lines or spots. This is the result of inadequate oral hygiene.

_____**SWOLLEN GINGIVA AND PERIODONTAL PROBLEMS**

Periodontal disease can be caused by accumulation of plaque and debris around the teeth and gums. Regular and proper flossing and brushing can usually prevent swollen, inflamed, and bleeding gums. Also, systematic/unknown causes can lead to progressive loss of supporting bone and recession of the gums. Should this condition become uncontrollable, orthodontics may have to be discontinued short of completion. This is a rare occurrence that is usually found in adults with pre-existing problems.

_____**ROOT RESORPBTION**

Root resorption is a blunting of the root tips and occurs to a varying degree during all orthodontic treatment, but it is usually mild and does not affect the health or longevity of the teeth. The most common teeth affected are the upper and lower front teeth. X-rays will be taken to monitor the reaction of the roots during treatment. There are occasions when teeth spontaneously devitalize due to orthodontic treatment. If this occurs, root canal therapy will be needed for the continuation of treatment.

_____**JAW PAIN/CLICKING**

Jaw joint (TMJ) pain and clicking in the joints may occur anytime during one's lifetime. The symptoms of TMJ problems may express themselves in many ways, such as limited opening, popping or clicking sounds when the mouth is opened or closed. Multiple factors are usually the cause of this condition. It is more common in females in their late teens and early twenties and in the late forties. The emotional state of a person has a direct relationship to the severity of the joint pain. A less than ideal bite may be just one cause for this condition. Many dentists and other professionals s believe the TMJ problems are all bite related, but this is simply not so. Many TMJ problems cannot be solved by "fixing the bite", as they may be caused by abnormalities within the bite relationship, but orthodontics alone may not result in a reversal of the joint damage. If any of the above symptoms have been noticed, whether they were present before and stopped or are still present, it is important information for the orthodontist to know prior to the beginning of treatment.

ACKNOWLEDGEMENT OF INFORMED CONSENT

I hereby acknowledge that the major treatment considerations and potential risks of orthodontic treatment have been presented to me. I have read and understand this form and also understand that there may be other problems that occur less frequently or are less severe, and that the actual results may be different from the anticipated results. Dr. Christensen has discussed the orthodontic treatment with me. I have been asked to make a choice about that treatment. I have been presented information to aid in the decision-making process, and I have been given the opportunity to ask Dr. Christensen all questions I have about the proposed orthodontic treatment and information contained in this form.

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment. I consent to orthodontic treatment for the above individual, by Dr. Christensen and his staff. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Dr. Christensen and staff to provide other healthcare providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, Dr. Christensen and staff have no responsibility for any further release by the individual receiving this information.

SURGICAL SUPPLEMENT

If the orthodontic treatment plan includes correction of the malocclusion by orthodontic appliance (braces) therapy in conjunction with orthognathic (corrective jaw) surgery, I understand that oral surgery is necessary in conjunction with the above patient's orthodontic treatment. I authorize Christensen Orthodontics to communicate with the surgeon and release information from the above patient's treatment record to the designated surgeon. I acknowledge that expenses incurred from the surgery are separate from orthodontic treatment expenses, and I will be responsible to the surgeon/hospital for all such expenses.

I understand that if I do not complete the surgical component of the treatment plan that I may have a compromised treatment result and other complications. I hereby agree not to hold Dr. Christensen and staff liable for any compromised treatment resulting from my failure for any reason to follow the treatment plan.

_____

Patient Name (Please Print)

_____ _____

Signature/Patient, Parent or Guardian Date