Today's Date: _____/_____/_____

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

ABOUT YOU

Name:_____
Last First
Male: _____ Female: _____
Mailing Address: _____
City:_____ State:_____Zip:_____
How long at this address?: _____
Date of Birth: _____/_____/_____ Age: _____
Social Security Number: _____/_____/_____
Home Phone: _____/_____/_____
Cell Phone: _____/_____/_____
Email: _____
Employer: _____
How long with this employer: _____

SPOUSE

Name:_____
Last First
Male: _____ Female: _____
Mailing Address: _____
City:_____ State:_____Zip:_____
How long at this address?: _____
Date of Birth: _____/_____/_____ Age: _____
Social Security Number: _____/_____/_____
Home Phone: _____/_____/_____
Cell Phone: _____/_____/_____
Email: _____
Employer: _____
How long with this employer: _____

☐ PLEASE CHECK IF THERE IS NO INSURANCE

☐ Check if insurance is the same ☐ Check if insurance benefits have changed

PRIMARY DENTAL INSURANCE

Insured Name: _____
Relationship to patient: _____
Insured Date of birth: _____/_____/_____
Social Security Number:_____/_____/_____
Employer:_____
Group #: _____ ID#: _____
Insurance Company: _____
Ins. Phone Number: _____

PRIMARY MEDICAL INSURANCE

Insured Name: _____
Relationship to patient: _____
Insured Date of birth: _____/_____/_____
Social Security Number: _____/_____/_____
Employer:_____
Group #: _____ ID#: _____
Insurance Company: _____
Ins. Phone Number: _____

Who may we thank for referring you to our office?

_____

In the event of an emergency, who should we contact?

Name: _____
Relationship: _____ Phone #: _____/_____/_____

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

DENTAL HISTORY *CONFIDENTIAL*

Current Dentist: _____ Last Visit: _____

Do you like your smile? ____Yes _____No

Have you ever been evaluated for orthodontics? ____Yes _____No

Your current dental health is: ____Good _____Fair _____ Poor

Do you brush and floss daily? ____Yes _____No

Have you ever had injury to your face/mouth? ____Yes _____No

Do you or have you ever experienced pain/discomfort in your jaw? ____Yes _____No

MEDICAL HISTORY

Primary Care Physician (PCP):_____ Facility:_____ Phone:_____

Are you currently under the care of a physician? ____Yes _____No

Please explain_____

Are taking any prescriptions/over-the-counter drugs? ____Yes _____No

Please list any/all:_____

Do you use tobacco of any form? ____Yes _____No

Have you had a Sleep Study done? ____Yes _____No If yes, where? _____

FOR WOMEN: Are you pregnant? ____Yes _____No Weeks:_____

Have you ever had any of the following:

___Abnormal Bleeding	___Difficulty breathing	___Hospital Stay/operations
___AIDS/HIV+	___Epilepsy/Convulsions	___Kidney Problems
___Anemia/Radiation	___Fainting	___Liver Problems
___Artificial bones/joints	___Hearing Impairment	___Lupus
___Asthma	___Heart attack/stroke	___Measles
___Arthritis	___Heart Murmur	___Mitral valve Prolapse
___Blood transfusion	___Hepatitis	___Rheumatic Fever
___Cancer/Chemo	___Heart Surgery	___Scarlet Fever
___Congenital Heart Defect	___High Blood Pressure	___Severe/Frequent headaches
___Diabetes	___Low Blood Pressure	___Tuburculosis(TB)
___Sleep Apnea		

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

_____

Are you allergic to any of the following?: ___Codeine ___Penicillin ___Sulfa ___Anesthetics

___Metals/Plastics ___Latex

Please list any other drugs/materials that you are allergic to: _____

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 patient _____ Date _____/_____/_____

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

Today's Date: _____/_____/_____

PATIENT INFORMATION

PATIENT NAME: _____ Date of Birth: _____/_____/_____

Chief Complaints: _____

SLEEP HISTORY

Lights Out: _____ ☐ AM ☐ PM

Lights On: _____ ☐ AM ☐ PM

Number of awakenings during the night: _____

Trips to the bathroom at night: _____

Do you take any sleep aids to help you sleep? ☐ YES ☐ NO

If yes, what kind? _____

MEDICATIONS (including prescription and over the counter)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Do you have a history of any of the following? (*Check if "YES" to any of the following*)

____ Difficulty falling asleep
____ Difficulty staying asleep
____ Snoring
____ Witnessed Apneas
____ Gasping/Choking during sleep
____ Sweating/perspiring during sleep
____ Drooling
____ Dry mouth upon awakening
____ Teeth grinding/clenching
____ Talking in your sleep
____ Heart palpitations
____ Ischemic Heart Disease
____ Cardiac Arrhythmia's
____ GERD/Reflux/Heartburn
____ Excessive daytime sleepiness
____ Tired/Fatigued during the day
____ Nasal allergies/Hay fever/nasal congestion
____ Asthma
____ TMJ Pain/Discomfort
____ Hypertension
____ Pulmonary Hypertension
____ Depressed mood/Irritability
____ Mood Disorders
____ Anxiety/Stress
____ Difficulty with concentration
____ Cognition Impaired
____ Memory Problems
____ Chest Pain/Chest discomfort
____ Shortness of breath during the day
____ Acting out dreams
____ Morning Headaches
____ Excessive movement during sleep

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

						Co-morbidities +1 for each Yes response
High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○	Score
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○	
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○	
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○	Do not assign any points for these eight responses
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○	
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○	
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○	

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions. If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Signature	Area Code / Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total**