CHILD HEALTH HISTORY FORM

Today's Date: _____/_____/_____

YOUR CHILD

Patient ID#_____

Child's Name_____
Last First

Male: _____ Female: _____

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

Child's Mailing 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: _____

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: _____

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?:_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS CHILD(Please check): Mom____ Dad____ Split_____

If SPLIT account, who is the custodial parent for this child? (Please Check) Mom____ Dad____

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

EXISTING PATIENTS: ☐ **Insurance is the same** ☐ **I have new insurance benefits**

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

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