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: _____

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 patient _____ Date _____/_____/_____

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

Sleep, Breathing & Habit Questionnaire

Patient's Name: _____ Age: _____ Date: _____

Please indicate if your child experiences any of the symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occurs Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during the day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bedwetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Allergic symptoms
18. _____ Ear infections
19. _____ Short attention span
20. _____ Trouble Focusing
21. _____ Difficulty listening/often interrupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech problems *
28. _____ Avoidance behavior towards food or certain types of food

HEIGHT(in inches): _____ **WEIGHT**(in pounds): _____

*Speech Questionnaire - to be filled out only if #27 was indicated above Please check all that apply to your child

_____ Is it difficult to understand your child's speech?
_____ Difficult to understand over the phone?
_____ Nasal speech?
_____ Hoarseness?
_____ Others have difficulty understanding speech?
_____ Gets frustrated when people can't understand speech?
_____ Speech sounds abnormal?
_____ Sometimes omits consonants?
_____ Uses M, N, NG instead of P, V, S, Z sounds?
_____ Swallowing problems with liquids and solids getting into nose?

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