Christensen Orthodontics

Troy Christensen, DDS, MS
Specialist in 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- Adult

First Name: _____ *Last Name:* _____ *Middle Name:* _____
Age: _____ *Date of Birth:* _____ *Nickname:* _____*Male or Female:* _____
Home Address: _____ *City:* _____ *State:* _____*Zip:* _____
Phone Number: _____ *Cell Phone:* _____ *Email Address:* _____
Social Security #: _____*Occupation:* _____ *How Long?* _____
Employer: _____*Employers Address:* _____*City:*_____ *State:* _____*Zip:*_____
General Dentist: _____*Who may we thank for referring you to our office?* _____
Have we treated another member of your family? _____*If yes, Name:* _____
What are the main concerns that you would like orthodontics to accomplish? _____
Have you visited an orthodontist before? _____ *If yes, for what reason?* _____
Anything you would like to discuss with the doctor in private? _____

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 #:*_____

Medical History

Are you currently under the care of a physician? _____ *If Yes, for what reason?* _____
Physician's Name: _____ *Phone #:* _____
Do you have any history of major illnesses? _____ *If Yes, Please describe:* _____
List any allergy or drug sensitivity that you have: _____
Currently taking any medications? _____ *If Yes, please list:* _____
Have you been treated for any of the following?

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

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Dental History

Do you require antibiotics before dental treatment? _____ If Yes, please explain: _____
Have you been informed that you are missing any permanent teeth? _____
Have you been informed that you have any extra permanent teeth? _____
Have you had any injuries to your face, mouth or chin? _____ If Yes, Please explain: _____
Have you ever had any pain/tenderness in the jaw joint (TMJ/TMD)? _____
Do/Did you have any of the following habits?

□ *Grinding Teeth* □ *Finger/Thumb Sucking* □ *Tongue Thrusting* □ *Chronic Mouth Breathing*
□ *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 medical status.

I hereby authorize the 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:* _____