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- Child or Teen

First Name: ______________________________ Last Name: ______________________________ Middle Name: _______________
Age: _____________ Date of Birth: __________________ Nickname: ______________________ Male or Female: ______________
Home Address: ____ City: ______________ State: _________ Zip:______________
Phone Number: _______________________________ Email Address: ____
Who is with patient today? __________________________________ Relationship to patient: ______________________________
Patient's general dentist: ________________________ Who may we thank for referring you to our office? ____________________
Have we treated another member of the family? _________Name____
Has your child visited an orthodontist before? _______ If YES for what reason? ____
What are the main concerns that you would like orthodontics to accomplish? ____
Anything you would like to discuss with the doctor in private? ____

Parents Information

Father

Marital Status: Single Married Widowed Divorced Separated Domestic Partner
Father Step Father Guardian First Name: ___________________Last Name: ___________________Middle Name: ________
Date of Birth: ___________ Social Security #:_________________Cell Phone: ________________Home Phone: _______________
Address: ____City: ______________State: _________ Zip: ______________
Employer: ____ Employer's Number: ____________________________________

Mother

Marital Status: Single Married Widowed Divorced Separated Domestic Partner
Mother Step Mother Guardian First Name: ____________________Last Name: __________________Middle Name: ________
Date of Birth: ___________Social Security #: __________________ Cell Phone: _______________Home Phone: _______________
Address: ____ City: _______________ State: __________ Zip: ______________
Employer: ____ Employers Number: ____________________________________

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 #:_______________________

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Medical History

Is the child currently under care of a physician? ____________ If Yes, for what reason? _______________________________________
Child's Physician's Name: ____ Phone #: ________________________________
Does your child have any history of major illnesses? ____________ If Yes, Please describe: ___________________________________
List any allergy or drug sensitivity that your child has: ____
Currently taking any medications? _________ If Yes, please list: ____
Has your child reached puberty? _____________________
Has your child been treated for any of the following?

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

Dental History

Does your child require antibiotics before dental treatment? ____________ If Yes, please explain: ______________________________
Has your child tonsils/adenoids been removed? ___________ If Yes, What age? ____
Have you been informed that your child is missing any permanent teeth? ____
Have you been informed that your child has any extra permanent teeth? ____
Has your child had any injuries to their face, mouth or chin? ______ If Yes, Please explain: ___________________________________
Has your child ever complained of pain/tenderness in the jaw joint (TMJ/TMD)? ____
Does/Did your child have any of the following habits?

□ Grinding Teeth □ Finger/Thumb Sucking □ Prolonged Bottle/ Pacifier □ Mouth Breather
□ 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 child's medical status.

I hereby authorize 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: ____