Christensen, Freeseman & Richter Orthodontics

Patient Information

Today's Date ____________20_____

Patient's Name ____DOB____/____/____ ( ) Male ( ) Female

Last *First* *MI*

Patient's Address________________________________City__________________________State______Zip Code________

Appointment Reminders sent to Cell # (____)______________________Email_______________________________________

Name of Emergency Contact _________________________________ Emergency Contact Phone #___________________

Patient's Employer (*if applicable*)____

Responsible Party Information

Patient's Residence ( ) Both Parents ( ) Father ( ) Mother ( ) Other__________________________________

Father's Information ☐ Dad ☐ Guardian

Legal Name ____________________________
Birthdate __________ SSN #_______________
Cell Phone # __________________________
Email _______________________________
Address If Different Than Patient
____
City __________________________________
State _______________ Zip Code _________
Employer _____________________________
Father's Occupation ____________________
Spouse's Name _________________________
Spouse's Phone #_______________________

Mother's Information ☐ Mom ☐ Guardian

Legal Name ___________________________________
Birthdate __________ SSN #______________________
Cell Phone # ________________________________
Email _____________________________________
Address If Different Than Patient
____
City____
State __________________ Zip Code ____________
Employer ___________________________________
Mother's Occupation _________________________
Spouse's Name _______________________________
Spouse's Phone # _____________________________

Patient Insurance

Is Patient Covered by **DENTAL** Insurance (*not medical*) ( ) YES ( ) NO

Primary Policy Holder's Name_______________________________________ DOB____/____/____

Name of Insurance Company_____________________________

Ins. ID # or SSN# of Policy Holder____

Employer________________________________ Policy Holder Relationship to Patient_________________________

☐ Copy of Insurance Card Provided **OR** Complete the Following Info:

Insurance Company Address _________________________City, State, Zip _________________________________

Insurance Company Phone #_________________________ Group # _______________________________________

Do You Have Dual **DENTAL** Coverage ( ) YES ( ) NO

Primary Policy Holder's Name__________________________ DOB____/____/____

Name of Insurance Company_____________________________

Ins. ID # or SSN# of Policy Holder____

Employer________________________________ Policy Holder Relationship to Patient_________________________

☐ Copy of Insurance Card Provided **OR** Complete the Following Info:

Insurance Company Address _________________________City, State, Zip _________________________________

Insurance Company Phone #_________________________ Group # _______________________________________

Authorization and Signature

I have reviewed the Acknowledgement of Notice Privacy Practices (HIPPA) as displayed on the office wall. This office reserves the right to verify credit status of potential patients and/or parents prior to extending credit for treatment. I authorize the dental staff to preform necessary services the patient may need. *Signature* ______________________________________ *Date*_______________________

PLEASE COMPLETE BACKSIDE

Today's Date ____________20_____
Patient's Name ____

Medical History

Physician's Name: ____ Phone # ________________________________

Address : ______________________________________City _________________________State _______ Zip Code________
Is the patient currently under the care of a physician? □YES □NO Date of last visit: ______________________
Please describe patient's current physical health: □ Good □ Fair □Poor

Has the patient ever had any of the following medical problems?

□YES □NO Abnormal Bleeding
□YES □NO Allergies to any Drugs
□YES □NO Allergic to Latex / Metals
□YES □NO Allergic to Plastic
□YES □NO Asthma
□YES □NO Arthritis
□YES □NO Anemia / Radiation Treatment
□YES □NO Blood Transfusion
□YES □NO Cancer / Chemotherapy
□YES □NO Congenital Heart Defect
□YES □NO Convulsions
□YES □NO Diabetes
□YES □NO Difficulty Breathing
□YES □NO Drug / Alcohol Abuse
□YES □NO Epilepsy / Seizures/ Fainting Spells
□YES □NO Emphysema / Glaucoma
□YES □NO Fever Blisters / Herpes
□YES □NO Handicaps / Disabilities
□YES □NO Hearing Impairment
□YES □NO Heart Attack / Stroke
□YES □NO Heart Surgery / Pacemaker
□YES □NO Hemophilia / Abnormal Bleeding
□YES □NO Hepatitis
□YES □NO High / Low Blood Pressure
□YES □NO HIV +/ AIDS
□YES □NO Kidney / Liver Problems
□YES □NO Mitral Valve Prolapse
□YES □NO Psychiatric Problems
□YES □NO Rheumatic / Scarlet Fever
□YES □NO Shingles
□YES □NO Sinus Problems
□YES □NO Tuberculosis (TB)
□YES □NO Ulcers / Colitis
□YES □NO Venereal Disease

Hospitalized for any reason? ____
Please list any serious medical conditions: ____
Please list any allergies: ____
Please list any drugs (prescription /over the counter) the patient is currently taking: _________________________________
Have there been any injuries to the face, mouth, teeth, or chin? □YES □NO
Have adenoids or tonsils been removed? □YES □NO
Has puberty begun? □YES □NO
Has menstruation begun? (Girls) □YES □NO
For Women: Are you pregnant? □YES □NO Week# _________

Does the patient have any of the following habits?

□YES □NO Clenching / Grinding Teeth
□YES □NO Lip Sucking / Biting
□YES □NO Mouth Breather
□YES □NO Nail Biting
□YES □NO Nursing Bottle Habits
□YES □NO Speech Problems
□YES □NO Thumb / Finger Sucking
□YES □NO Tongue Thrust

Dental History

General Dentist's Name: ____ Phone # _________________________

Address: ____City _______________________State _______ Zip Code________

Date of last visit: ______________________
Has the patient been informed of any missing or extra permanent teeth? □YES □NO
Has the patient ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? □YES □NO
Does the patient brush his/her teeth daily? □YES □NO
Floss his/her teeth daily? □YES □NO
What are the main concerns you would like orthodontics to accomplish? ____
Does the patient like their smile? □YES □NO
Has the patient ever been evaluated or had orthodontic treatment before? □YES □NO