

ALAN SCOTT  
**Christiansen & Nord**  
 PRACTICE LIMITED TO ORTHODONTICS



We are pleased to welcome you to our office. We hope you will find a kind and comfortable atmosphere. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you!

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_  M  F  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Previous address (if less than 3 years) \_\_\_\_\_

Home Phone \_\_\_\_\_ Wk # \_\_\_\_\_  
 Other Phone# \_\_\_\_\_ Marital Status  S  M  D  
 SSN \_\_\_\_\_ DL# \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Job title \_\_\_\_\_ No of years employed \_\_\_\_\_  
 Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_

Favorite Sports or Hobbies \_\_\_\_\_  
 Other \_\_\_\_\_  
 Incase of an Emergency Contact \_\_\_\_\_  
 Phone # \_\_\_\_\_ Relation \_\_\_\_\_

**INSURANCE INFORMATION**  YES  NO

Primary Insurance Company \_\_\_\_\_  
 Insured Name \_\_\_\_\_  
 Contact # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Employer \_\_\_\_\_  
 Coverage Amount \_\_\_\_\_ % up to \_\_\_\_\_ max \_\_\_\_\_ deduct

Secondary Insurance Name \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Contact # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Employer \_\_\_\_\_  
 Coverage Amount \_\_\_\_\_ % up to \_\_\_\_\_ max \_\_\_\_\_ deduct

**REFERRAL**

**WHO REFERRED YOU TO OUR OFFICE?**

- Dentist \_\_\_\_\_
- Friend \_\_\_\_\_
- Yellow Pages \_\_\_\_\_
- Other \_\_\_\_\_

**SPOUSE'S INFORMATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Home# \_\_\_\_\_ Wk # \_\_\_\_\_  
 Employer \_\_\_\_\_ Job title \_\_\_\_\_  
 No. of years employed \_\_\_\_\_ Marital Status \_\_\_\_\_  
 SSN \_\_\_\_\_ DL # \_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE**

Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Home# \_\_\_\_\_ Wk # \_\_\_\_\_  
 Employer \_\_\_\_\_ Job title \_\_\_\_\_  
 No of years employed \_\_\_\_\_ Marital Status \_\_\_\_\_  
 SSN \_\_\_\_\_ DL# \_\_\_\_\_

Orthodontics for kids of all ages!!!

Please complete the Dental and Medical History on the back page. Thank you!

In your words, what is the orthodontic problem? \_\_\_\_\_

Have you had any previous orthodontic treatment or consultation?  Yes  No

If so, what work was completed, and by whom? \_\_\_\_\_

Has any other family member had orthodontics? \_\_\_\_\_

If so, what work was completed and by whom? \_\_\_\_\_

Were the results acceptable?  Yes  No

Do you now have or have you ever experienced pain or discomfort in your jaw joint?  Yes  No

Do you grind your teeth?  Yes  No

Do you have any speech problems?  Yes  No

Do you have or have you ever had any thumb or finger sucking habits?  Yes  No

Do you usually breathe through your mouth while awake?  Yes  No

Have you ever experienced an adverse reaction during a medical or dental procedure?  Yes  No

Have you ever received serious trauma or injury to the teeth, face, jaws, or head?  Yes  No

Will you best describe the patient's attitude toward orthodontic treatment:

- Wants treatment       Treatment is necessary       Unwilling, but agrees       Uncooperative

## MEDICAL HISTORY

Do you have, or have you ever had:  Diabetes       Heart Murmur       Artificial joints or heart valves

Are you under the care of a physician for a specific condition?  Yes  No

If yes, please describe \_\_\_\_\_

Are you taking any medications?  Yes  No

If yes, please list \_\_\_\_\_

Please check if you had any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Convulsions or Epilepsy      | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Difficulty Breathing         | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Asthma or Hayfever      | <input type="checkbox"/> Endocrine or Growth Problems | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Tuberculosis            |

## AUTHORIZATION

I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform the doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_