ADULT HEALTH HISTORY FORM

Today's Date: _____/_____/_____

CHRISTENSEN ORTHODONTICS
Advancing Treatment · Transforming Lives

ADULT PATIENT

Name:_____
Last First
Male: _____ Female: _____
Mailing Address: _____
City:_____ State:_____Zip:_____
How long at this address?: _____
Date of Birth: _____/_____/_____ Age: _____
Social Security Number: _____/_____/_____
Home Phone: _____/_____/_____
Cell Phone: _____/_____/_____
Email: _____
Employer: _____
How long with this employer: _____

SPOUSE

Name:_____
Last First
Male: _____ Female: _____
Mailing Address: _____
City:_____ State:_____Zip:_____
How long at this address?: _____
Date of Birth: _____/_____/_____ Age: _____
Social Security Number: _____/_____/_____
Home Phone: _____/_____/_____
Cell Phone: _____/_____/_____
Email: _____
Employer: _____
How long with this employer: _____

☐ **PLEASE CHECK IF THERE IS NO INSURANCE**

☐ Check if insurance is the same ☐ Check if insurance benefits have changed

PRIMARY DENTAL INSURANCE

Insured Name: _____
Relationship to patient: _____
Insured Date of birth: _____/_____/_____
Social Security Number:_____/_____/_____
Employer:_____
Group #: _____ ID#: _____
Insurance Company: _____
Ins. Phone Number: _____

PRIMARY MEDICAL INSURANCE

Insured Name: _____
Relationship to patient: _____
Insured Date of birth: _____/_____/_____
Social Security Number: _____/_____/_____
Employer:_____
Group #: _____ ID#: _____
Insurance Company: _____
Ins. Phone Number: _____

Who may we thank for referring you to our office?

_____

In the event of an emergency, who should we contact?

Name: _____
Relationship: _____ Phone #: _____/_____/_____

****PLEASE COMPLETE BOTH SIDES****

DENTAL HISTORY *CONFIDENTIAL*

Current Dentist: _____ Last Visit: _____

Do you like your smile? ____Yes _____No

Have you ever been evaluated for orthodontics? ____Yes _____No

Your current dental health is: ____Good _____Fair _____ Poor

Do you brush and floss daily? ____Yes _____No

Have you ever had injury to your face/mouth? ____Yes _____No

Do you or have you ever experienced pain/discomfort in your jaw? ____Yes _____No

MEDICAL HISTORY

Primary Care Physician (PCP):_____ Facility:_____ Phone:_____

Are you currently under the care of a physician? ____Yes _____No

Please explain_____

Are taking any prescriptions/over-the-counter drugs? ____Yes _____No

Please list any/all:_____

Do you use tobacco of any form? ____Yes _____No

Have you had a Sleep Study done? ____Yes _____No If yes, where? _____

FOR WOMEN: Are you pregnant? ____Yes _____No Weeks:_____

Have you ever had any of the following:

___Abnormal Bleeding
___AIDS/HIV+
___Anemia/Radiation
___Artificial bones/joints
___Asthma
___Arthritis
___Blood transfusion
___Cancer/Chemo
___Congenital Heart Defect
___Diabetes
___Sleep Apnea
___Difficulty breathing
___Epilepsy/Convulsions
___Fainting
___Hearing Impairment
___Heart attack/stroke
___Heart Murmur
___Hepatitis
___Heart Surgery
___High Blood Pressure
___Low Blood Pressure
___Hospital Stay/operations
___Kidney Problems
___Liver Problems
___Lupus
___Measles
___Mitral valve Prolapse
___Rheumatic Fever
___Scarlet Fever
___Severe/Frequent headaches
___Tuburculosis(TB)

Please list any other serious medical conditions/problems you may have: _____

_____

Are you allergic to any of the following?: ___Codeine ___Penicillin ___Sulfa ___Anesthetics
___Metals/Plastics ___Latex

Please list any other drugs/materials that you are allergic to: _____

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 _____/_____/_____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name	
Weight	Pounds	**Age**	Years	Gender Male ○ Female ○
Height	Feet	Inches	**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	Total all 6 boxes from above If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	Point Total

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ADULT SLEEP, BREATHING & HABIT ASSESSMENT

Today's Date _____/_____/_____

Patient's Name _____ Birthday _____/_____/_____ Age_____

Medical issues: _____ Medications taking: _____

Previous clip or release of tongue? _____ (Date)_____

Sleep History:

Lights out: _____ AM / PM
Lights on: _____ AM / PM
Number of awakenings during the night _____

Trips to the bathroom at night? _____
Do you taken any sleep aids? Y / N
If yes, which ones? _____

Have you experienced any of the following issues? Please check or elaborate as needed.

Speech:

___ Frustration with communication
___ Difficult to understand by others
___ Difficulty speaking fast
___ Difficulty getting words out (groping for words)
___ Trouble with sounds (which?)_____
___ Speech delay (when?)_____
___ Stuttering
___ Speech harder to understand in long sentences
___ Speech therapy (how long)_____
___ Mumbling or speaking softly
___"Baby Talk"

Feeding:

___ Frustration when eating
___ Slow Eater (don't finish meals)
___ Graze on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky with textures
___ Chocking or gagging on food
___ Spits out food
___ Other:

Sleep Issues (Check all that apply)

___ Difficulty Falling Asleep
___ Difficulty Staying Asleep
___ Snoring
___ Witnessed Apneas
___ Gasping/Choking during sleep
___ Sweating/perspiring during sleep
___ Sleeps in strange positions
___ Moves around a lot at night (kicks)
___ Wakes easily or often
___ Grinds teeth while sleeping
___ Sleeps with mouth open
___ Dry mouth upon awakening
___ Teeth grinding/clenching
___ Talking in your sleep
___ Heart Palpitations

___ Ischemic Heart Disease
___ Cardiac Arrhythmia's
___ Tired/Fatigue during the day
___ Excessive Daytime sleepiness
___ Nasal allergies/congestion
___ Asthma
___ Pulmonary Hypertension
___ Depressed mood/irritability
___ Mood Disorders
___ Anxiety/Stress
___ Difficulty with concentration
___ Cognition Impaired
___ Chest pain/chest discomfort
___ Shortness of breath during the day
___ Acting out dreams

Other related issues:

___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Mouth open /mouth breathing during the day
___ Tonsils or adenoids removed previously

___ Ear tubes previously
___ Reflux (medicated or not)
___ Hyperactivity / Inattention
___ Constipation

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

CHRISTENSEN ORTHODONTICS
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Christensen Orthodontics Sleep Apnea Informed Consent

The purpose of this memorandum is to inform the patient of the course of events that they may expect during Schwartz treatment. It emphasizes the need for patient cooperation and points out the risks and limitations of Schwartz treatment. You are encouraged to read the following information, ask any questions that come to mind, and then consent to our treatment by initialing and signing this form. This is standard procedure in our practice.

1. TYPICAL SCHWARTZ TREATMENT

____SCHWARTZ THERAPY

Schwartz appliance therapy for midfacial development is a relatively new therapy, and not practiced by all dentist and orthodontist. Schwartz appliance therapy has effectively treated many patients. Although there are no guarantees the Schwartz appliance therapy will be effective for you, as everyone we treat is different and there is many factors influencing the development of the maxilla. The full effect of the Schwartz appliance is yet to be determined. It is important to recognize that even when therapy is effective, there may be a period of time before the Schwartz appliance will give you maximum relief of symptoms. The Schwartz appliance is a biometric appliance that tries to mimic normal function and, therefore, encourage normal development of the jaws. Just as your symptoms took time to fully develop, this technique can take a long time to resolve your symptoms. The standard protocol for development is approximately 24 months, but is directly affected by the severity of an individual's case and the compliance of the patient with treatment.

____TREATMENT TIME/APPOINTMENTS

Follow-up visits can be every few weeks or every couple months Theses follow up visits are mandatory to insure proper fit and to assure a healthy condition, as well as maximum, timely development of your mouth and jaw. Following the approximate 18-36 month development protocol, scans and images are required to test the position of your jaw and teeth. Periodic photographic documentation is required. From that point depending on the amount of development, we will reassess your case and treatment.

____ SLEEP RECORDS

I hereby authorize Christensen Orthodontics to edit, copy, exhibit, publish and distribute any photo for purposes of publicizing or for any other lawful purpose, including the use of the photographs on the Christensen Orthodontics Facebook page or other social media sites. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein any likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photographs.

2. WHAT YOU CAN EXPECT DURING TREATMENT

____COOPERATION IS ESSENTIAL

Successful treatment can only be obtained with a team effort. In order to complete treatment, with the best results, and in the amount of time on your treatment plan, the patient must do the following:

-Keep Appointments
-Practice good oral hygiene; clean your teeth and appliances after every meal
-Wear appliances as instructed
-Inform office immediately of any broken or loose parts of your appliance

FAILURE TO FOLLOW THE GUIDELINES, INCLUDING ANY INSTRUCTION FROM THE DOCTOR AT THIS PRACTICE, MAY RESULT IN LONGER TREATMENT.

____ FUNCTIONAL FRENULOPLASTY SURGERY

A frenuloplasty may be diagnosed and recommended during or after orthodontic/Sleep Apnea treatment. Frenuloplasty is a procedure to correct a congenital condition when the lingual (tongue) or labial (lip) frenulum is tight, resulting in restriction of function. If this procedure is needed further discussion will occur.

_____ORAL SURGERY

Some of the malocclusions are so severe that orthodontics alone cannot obtain adequate results; therefore, jaw surgery may be required in order to achieve acceptable and stable results. Should surgery be indicated, further discussion will occur.

3. ADDITIONAL FEES

____DAMAGED APPLIANCES

There is a fee for broken and/or damaged appliances. This is a per appliance fee. The fee is $408 for an upper or lower. The Fee is $520 for a lower with MAD. The fee is $922 for an upper and lower with MAD.

____NO CALL NO SHOW

Time is valuable for everyone. Please arrive on time for your appointments so we can ensure that all patients are in and out in their scheduled appointment times. If you are more than 10 minutes late for your appointment, you will be placed on standby or asked to reschedule. It will state in each patients contract, that if you no show your appointment, you will be charged $25 NO SHOW FEE. Please be sure that if you can't make it to your appointment, that you call our office to reschedule or the fee will be charged to your account.

4. POTENTIAL RISKS AND LIMITATIONS OF TREATMENT

_____SIDE EFFECTS AND COMPLICATIONS OF ORAL APPLIANCE THERAPY

Published studies show that short-term side effects of oral appliance use many include, but are not limited to, excessive salivation, difficulty swallowing with appliance in place, sore jaw, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term changes in the bite. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustments of the appliance. Long-term complications may include a chance of gingival recession and if this occurs that the patient is responsible for any further treatment, changes in bite may be permanent, resulting from tooth movement, or jaw repositioning (which is the desired effect with appliance therapy). These complications may not be fully reversible once appliance therapy is discontinued. The desired effect of the Schwartz appliance specifically (in most cases) is to remodel the jaw bone, move teeth and jaw position to enhance craniofacial development. If not fully achieved, restorative dental treatment, orthodontic intervention or other treatments may be required, for which you will be responsible.

____ALTERNATIVE TREATMENTS

Other acceptable treatments for your condition includes orthodontics by a specialist and/or various surgeries. It is your decision to choose Schwartz appliance therapy to treat your various symptoms, and you are aware there is a possibility it may not be completely effective for you. It is your responsibility to

report the occurrence of side effects and to address any questions, to Dr. Christensen. Failure to treat your condition may lead to worsening symptoms.

ACKNOWLEDGEMENT OF INFORMED CONSENT

I hereby acknowledge that the major treatment considerations and potential risks of Schwartz treatment. I have read and understand this form and also understand that there may be other problems that occur less frequently or are less severe, and that the actual results may be different from the anticipated results. I have been presented information to aid in the decision-making process, and I have been given the opportunity to ask Dr. Christensen all questions I have about the proposed orthodontic treatment and information contained in this form.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Dr. Christensen and staff to provide other healthcare providers with information regarding the above individual's orthodontic, sleep or care as deemed appropriate. I understand that once released, Dr. Christensen and staff have no responsibility for any further release by the individual receiving this information.

SURGICAL SUPPLEMENT

If the orthodontic treatment plan includes correction of the malocclusion by orthodontic appliance (braces) therapy in conjunction with orthognathic (corrective jaw) surgery, I understand that oral surgery is necessary in conjunction with the above patient's orthodontic, sleep or airway treatment. I authorize Christensen Orthodontics to communicate with the surgeon and release information from the above patient's treatment record to the designated surgeon. I acknowledge that expenses incurred from the surgery are separate from orthodontic, sleep or airway treatment expenses, and I will be responsible to the surgeon/hospital for all such expenses.

I understand that if I do not complete the surgical component of the treatment plan that I may have a compromised treatment result and other complications. I hereby agree not to hold Dr. Christensen and staff liable for any compromised treatment resulting from my failure for any reason to follow the treatment plan.

_____

Patient Name (Please Print)

_____ _____

Signature/Patient, Parent or Guardian Date