

**WELCOME TO  
DR. DON JORGENSEN'S OFFICE**

Our practice is here to provide our patients with the best orthodontic treatment available today. Please answer the questions below so that we can get to know you better!!

What name do you like to be called by? \_\_\_\_\_

I think wearing braces would be \_\_\_\_\_

What is your favorite animal/pet? \_\_\_\_\_

What kind of music do you like and who are your favorite singers, bands or groups? \_\_\_\_\_

What kind of books or movies do you like? \_\_\_\_\_

Do you have a favorite website? What is it? \_\_\_\_\_

What kinds of sports do you like to play/watch? \_\_\_\_\_

What subjects do you like most in school? \_\_\_\_\_

What would you like to do after you graduate? \_\_\_\_\_

In my spare time, I like to \_\_\_\_\_

Tell us something special about yourself \_\_\_\_\_

Please list the names of any of your friends or family members who come to our office. \_\_\_\_\_

**THANK YOU, we look forward to meeting you soon!!**

375 E. Horsetooth Rd.,  
Bldg. 3-101  
Fort Collins, CO 80525  
(970) 223-4700

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Suite 6  
Windsor, CO 80550  
(970) 674-7331

124 Cole Shopping Center  
Cheyenne, WY 82001  
(307) 635-9202

# WELCOME TO Dr. J's

We would like to welcome you and your child to our office.  
Our goal is to make every child's visit pleasant and educational.

<p>1. Please tell us about your child: Today's date: _____ Child's Name: _____                     LAST                    FIRST                    MI Nickname: _____ Birthdate: ___/___/___ Age: ___                     <input type="checkbox"/> Male   <input type="checkbox"/> Female School: _____ Grade: _____ Child's home address: _____ _____ Child's home phone number: (____)____-_____</p>	<p>4. Person Financially Responsible for Account: Name: _____ Relation: _____ Billing Address: _____ _____ Previous Address: _____ _____ Hm# (____)____-_____ Employer: _____ How long at current job: _____ Wk# (____)____-_____ SSN# _____ DL# _____</p>
<p>2. Who is accompanying your child today? Name: _____ Relation: _____ Does this person have legal custody of this child?                     Yes   No Whom may we thank for referring you? _____ Sibling names and ages: _____ _____ General Dentist Name: _____ Last Visit: _____ Parents' marital status: ____ Single   ____ Married   ____ Divorced ____ Separated   ____ Widowed   ____ Partnered</p>	<p>Person responsible for making appointments: Name: _____ Hm# (____)____-____ Wk# (____)____-____</p>
<p>3. Mother's Information: Mother/Stepmother Name: _____ Birthdate: _____ Hm#(____)____ Hm email: _____ Employer: _____ Title: _____ How long at current job? _____ Wk#(____)____ Wk email: _____ SSN: _____ DL# _____</p>	<p>5. Primary Orthodontic Insurance Orthodontic Coverage? ____ Yes ____ No Insurance Company Name: _____ Insurance Company Ph# (____)____-_____ Policy Holder Name: _____ Relation to Patient: _____ Policy holder birthdate: ___/___/___ Employer: _____ Group# _____ Subscriber ID# _____ Subscriber SSN# _____ Insurance Company Address: _____ _____</p>
<p>Father's Information: Father/Stepfather Name: _____ Birthdate: _____ Hm#(____)____ Hm email: _____ Employer: _____ Title: _____ How long at current job? _____ Wk#(____)____ Wk email: _____ SSN: _____ DL# _____</p>	<p>Secondary Orthodontic Insurance Orthodontic Coverage? ____ Yes ____ No Insurance Company Name: _____ Insurance Company Ph# (____)____-_____ Policy Holder Name: _____ Relation to Patient: _____ Policy holder Birthdate: ___/___/___ Employer: _____ Group# _____ Subscriber ID# _____ Subscriber SSN# _____ Insurance Company Address: _____ _____</p> <p>****CONTINUED ON BACK****</p>

6. What are the main concerns that you would like to orthodontics to accomplish? \_\_\_\_\_

Has your child ever taken any of the following?

Fen-Phen      Redux      Pondimin

If so, when? \_\_\_\_\_

Has your child ever taken any of the following?

Zometa    Aredia    Boniva    Actonel    Fosamax

If so, when? \_\_\_\_\_

Has your child ever been evaluated for orthodontic treatment before?      Yes/No

Has your child ever had any injuries to face, mouth or chin?      Yes/No

Does your child play any musical instruments? If so, which ones? \_\_\_\_\_

Have tonsils and adenoids been removed? Yes/No

Have you been informed your child is missing or has extra permanent teeth?      Yes/No

Has your child ever had any pain/tenderness in His/her jaw joint (TMJ)?      Yes/No

Does your child brush his/her teeth daily?      Yes/No

Does he/she floss daily?      Yes/No

Child's Physician? \_\_\_\_\_

Ph # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Last Visit? \_\_\_\_\_

Is your child currently under the active care of this physician?      Yes/No

Has puberty begun?      Yes/No

Has menstruation begun? (Girls)      Yes/No

Please describe your child's current physical Health:      Good    Fair    Poor

List all drugs your child is currently taking: \_\_\_\_\_

Please list all drugs/things your child is allergic To: \_\_\_\_\_

9. I understand that the information 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.

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

\*This office will not be held responsible for any problems arising from information not disclosed.

I have verbally reviewed the medical/dental information provided with parent/guardian and patient name herein.

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

7. Has your child ever been diagnosed with any of the following diseases or medical conditions?

Y	N	Abnormal bleeding	Y	N	Convulsions/epilepsy
Y	N	ADD/ADHD			
Y	N	Allergies to Drugs	Y	N	Diabetes
Y	N	Allergies to Latex or Metals	Y	N	Handicaps/disabilities
Y	N	Allergies to Plastics	Y	N	Hearing impairment
Y	N	Any hospital stays			
Y	N	Any operations	Y	N	Heart Murmur
Y	N	Artificial bones/Joints/valves	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis A/B/C
Y	N	Cancer	Y	N	HIV/AIDS
Y	N	Congenital heart defect			Kidney/liver problems
			Y	N	Rheumatic/Scarlet Fever

Please provide additional information regarding any of the above listed conditions or any other medical problems:

Has your child ever exhibited any of the following?

Y	N	Clenching/Grinding of teeth	Y	N	Nursing problems
Y	N	Lip sucking/biting	Y	N	Speech problems
Y	N	Mouth breathing	Y	N	Thumb/Finger sucking
Y	N	Nail biting	Y	N	Tongue thrust

Emergency contact. Friend/Relative not residing with you:

Name: \_\_\_\_\_

Ph# (\_\_\_\_) \_\_\_\_-\_\_\_\_

10 I authorized the Orthodontist to share this patient's treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit pertinent treatment information to the insurance company for billing purposes only.

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

I have reviewed information originally provided and made appropriate changes:

Initials \_\_\_\_\_ Date \_\_\_\_\_

Intials \_\_\_\_\_ Date \_\_\_\_\_