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

1180 Main Street
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.

1. Please tell us about your child:
Today's date: _____
Child's Name: _____
LAST FIRST MI
Nickname: _____
Birthdate: ___/___/___ Age: ___
☐Male ☐Female
School: _____ Grade: _____
Child's home address: _____
_____
Child's E-mail address _____
Child's home phone number: (____)____-_____

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

3. Mother's Information: Mother/Stepmother
Name: _____ Birthdate: _____
Hm#(___)_____ Hm email: _____
Employer: _____ Title: _____
How long at current job? _____
Wk#(___)_____ Wk email: _____
SSN: _____ DL# _____

Father's Information: Father/Stepfather
Name: _____ Birthdate: _____
Hm#(___)_____ Hm email: _____
Employer: _____ Title: _____
How long at current job? _____
Wk#(___)_____ Wk email: _____
SSN: _____ DL# _____

4. Person Financially Responsible for Account:
Name: _____ Relation: _____
Billing Address: _____
_____
Previous Address: _____
_____
Hm# (___)____-_____
Employer: _____
How long at current job: _____
Wk# (___)____-_____
SSN# _____ DL# _____

Person responsible for making appointments:
Name: _____
Hm#____)____-_____Wk# (____)____-____

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: _____
_____

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: _____
_____

****CONTINUED ON BACK****

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 you 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☐ADD/ADHD
☐Y N☐Allergies to Drugs
☐Y N☐Allergies to Latex or Metals
☐Y N☐Allergies to Plastics
☐Y N☐Any hospital stays
☐Y N☐Any operations
☐Y N☐Artificial bones/ Joints/valves
☐Y N☐Asthma
☐Y N☐Cancer
☐Y N☐Congenital heart defect
☐Y N☐Convulsions/ epilepsy
☐Y N☐Diabetes
☐Y N☐Handicaps/ disabilities
☐Y N☐Hearing impairment
☐Y N☐Heart Murmur
☐Y N☐Hemophilia
☐Y N☐Hepatitis A/B/C
☐Y N☐HIV/AIDS
☐Y N☐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 you child ever exhibited any of the following?
☐Y N☐Clenching/Grinding of teeth
☐Y N☐Lip sucking/biting
☐Y N☐Mouth breathing
☐Y N☐Nail biting
☐Y N☐Nursing problems
☐Y N☐Speech problems
☐Y N☐Thumb/Finger sucking
☐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 collarborating 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

Submit Form