Welcome To Our Practice
Dr. Michael Christiansen, D.M.D
Creating beautiful smiles!

Patient: (Mr. Mrs. Ms. Dr.)_____M.I._____

Sex: Male / Female DOB____/____/_____ Age_____ Nick Name_____

Home Phone_____ Cell Phone_____ Work #_____

Home Address_____ City_____ State _____ Zip _____

Soc. Sec. #_____

____Married ____Divorced ____Legally Separated ____Widow ____Single Patient: Student _____Full Time ____Part Time

Employed: ____Not ____Full Time ____Part Time Have you ever been a patient of our practice? _____ Yes _____No

Nearest relative Not Living with you_____Relationship_____Tel.#_____

Primary Dental Insurance

Insurance Co. Name_____ Policy Holder DOB _____

Policy Holder_____ Group #_____

Policy Holder Employer_____ Policy holder SS #_____

Policy Holder Address_____

Policy Holder Phone #_____ Relationship to Patient_____

Secondary Dental Insurance

Insurance Co. Name_____ Policy Holder DOB_____

Policy Holder_____ Group #_____

Policy Holder Employer_____ Policy holder SS #_____

Policy Holder Address_____

Policy Holder Phone #_____ Relationship to Patient_____

PRIVACY POLICY

The privacy policy of Dr. Christiansen and Staff is posted in the reception area. Your signature below confirms your acknowledgement of this policy. If you would like a copy, they are available at the reception area.

X_____ _____

AUTHORIZED PERSON DATE

RELEASE OF INFORMATION

I authorize the release of medical and/or dental information, letters, radiographs, and photos so that these may be sent to or discussed with health care providers, insurance companies, or institutions that are or will be involved in my care or treatment or the processing of my insurance claim.

X_____ _____

INSURED OR AUTHORIZED PERSON DATE

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF DENTAL/ MEDICAL BENEFITS RENDERED TO **DR. MICHAEL CHRISTIANSEN.** Your signature on this form attests to the validity and truthfulness of your answers.

X_____ _____

INSURED OR AUTHORIZED PERSON DATE

FINANCIAL POLICY

It is your responsibility to know your coverage and benefits. Please verify your coverage with your insurance carrier prior to any procedure or surgery. If you have no insurance coverage payment is due at the time of service. If fees for service are deemed not covered or not medically necessary by your insurance carrier, this statement serves as notice that you will be financially responsible for all fees related to your plan of treatment. If your account is referred to a collection agency you will be responsible for all collection fees, court costs, and attorney fees.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY

X_____ _____

INSURED OR AUTHORIZED PERSON DATE

To our patients: Dr. Christiansen's primarily treats the area in and around your mouth and face, your mouth is a part of your entire body. Health problems you may have or medication that you may be taking, could have an important interrelationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit:_____

Patient: _____ D.O.B. _____

Do you have any of the following diseases or problems:	YES	NO	DK
Active Tuberculosis	____	____	____
Persistent cough greater than 3 weeks	____	____	____
Cough that produces blood	____	____	____
Been exposed to anyone with tuberculosis	____	____	____

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

	YES	NO	DK
Do your gums bleed when you brush or floss?	____	____	____
Are your teeth sensitive to cold, hot, sweets, or pressure?	____	____	____
Is your mouth dry?	____	____	____
Have you had any periodontal (gum) treatments?	____	____	____
Have you ever had orthodontic (braces) treatment?	____	____	____
Have you had any problems associated with previous dental treatments?	____	____	____
Is your home water supply fluoridated?	____	____	____
Are you currently experiencing dental pain or discomfort?	____	____	____
Do you have earaches or neck pain?	____	____	____
Do you have any clicking, popping, or discomfort in the jaw?	____	____	____
Do you brux or grind your teeth?	____	____	____
Do you have sores or ulcers in your mouth?	____	____	____
Do you wear dentures or partials?	____	____	____
Do you participate in active recreational activities?	____	____	____
Have you ever had a serious injury to your head or mouth?	____	____	____

Date of your4 last dental exam_____/_____/_____ Date of last dental x-rays_____/_____/_____

What was done at that time?_____

How do you feel about your smile?_____ Any concerns we should be aware of? _____

Medical Information

	YES	NO	DK
Are you under the care of a physician?	____	____	____
Are you in good health?	____	____	____
Has there been any change in your general health within the past year?	____	____	____

If yes, what condition is being treated? _____

Have you been hospitalized or had a serious illness in the past 5 years? ____ ____ ____

If yes, what was the illness or problem?_____

Are you allergic to local anesthetics, latex, or have drug allergies? ____ ____ ____

If you answered yes, please list _____

	YES	NO	DK
Artificial (prosthetics) heart valve	____	____	____
Previous infective endocarditis	____	____	____
Damaged valves in transplanted heart	____	____	____
Congential heart disease (CHD)	____	____	____
Unrepaired, cyanotic CHD	____	____	____
Repaired (Completely) in last 6 months	____	____	____
Repaired CHD with residual defects	____	____	____
Stroke			

Cardiovascular disease	____	____	____
Angina	____	____	____
Arteriosclerosis	____	____	____
Congestive heart failure	____	____	____
Damaged heart valves	____	____	____
Heart attack	____	____	____
Heart murmur	____	____	____
Low blood pressure	____	____	____
High blood pressure	____	____	____
Other congenital heart defects	____	____	____
Mitral Valve prolapse	____	____	____
Pacemaker	____	____	____
Rheumatic fever	____	____	____
Abnormal bleeding	____	____	____
Anemia	____	____	____
Blood transfusion (if Yes) Date _____	____	____	____
Hemophilia	____	____	____
AIDS or HIV infection	____	____	____
Arthritis	____	____	____
Autoimmune disease	____	____	____
Rheumatoid arthritis	____	____	____
Systemic lupus erythematosus	____	____	____
Asthma	____	____	____
Bronchitis	____	____	____
Emphysema	____	____	____
Sinus Troubles	____	____	____
Cancer/ Chemotherapy	____	____	____
Diabetes Type 1 or 2	____	____	____
Ulcers (In or around mouth area)	____	____	____
Stroke (if Yes) Date _____	____	____	____
Mental Health Disorders	____	____	____
Specific _____			
Severe Headaches/ migrains	____	____	____
Fainting Spells or seizures	____	____	____

WOMAN ONLY

Are you pregnant? If yes number of weeks _____	____	____	____
Taking birth control pills	____	____	____
Hormonal replacement	____	____	____
Nursing?	____	____	____

Do you drink alcoholic beverages?	____	____	____
If yes, how much alcohol did you drink in the last 24 hours? _____ How much do you typically drink in a week? _____			
Do you use controlled substances (drugs)	____	____	____
Do you use tobacco (smoking, snuff, chew, bidis)?	____	____	____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING **Prescription and over-the-counter medications including herbals please note:** this organization and its providers are not responsible for medications ordered by other organizations or providers. List below medications and dose below. If you have a list please provide it to the receptionist.

_____ **I CURRENTLY TAKE NO MEDICATIONS.**

Any other Medical Concerns we should be aware of?