imagine braces

Patient Biographical Information

First Name: | Middle Initial: | Last Name: | Nickname:

Birth date: | Gender: | Age | Social Security #:

Address: | City: | State: | Zip:

Main Phone: | 2nd/Cell Phone: | Email:

Please list the names of any friends or family currently in treatment with our practice:

List any sports, hobbies, or musical instruments played:

Whom may we thank for referring you to our practice?

Financial Party Information

First Name: | Middle Initial: | Last Name: | Nickname:

Address: | City: | State: | Zip:

Main Phone: | 2nd/Cell Phone: | Email:

Social Security #: | Employer: | Occupation:

Work Phone: | Relationship to Patient:

❑ No ❑ Yes Do you have insurance that covers orthodontics? If so please list below

Insurance Company: | Policy # | Insurance Phone #

2nd Insurance Company: | Policy # | Insurance Phone #

Dental History

Dentist Name: | Check-up Frequency: | Last Dental Visit:

❑ No ❑ Yes Has the patient had an orthodontic consultant or treatment? If so, when?

What is the patients main orthodontic concern?

Please select YES if the patient has had any of the conditions listed below either now or in the past.

❑ No ❑ Yes Speech problems/therapy?
❑ No ❑ Yes Grind or clench teeth?
❑ No ❑ Yes Oral habits (thumb/finger sucking, lip/nail biting)?
❑ No ❑ Yes Injury to face, jaw, teeth or mouth?
❑ No ❑ Yes Discomfort from teeth or gums?
❑ No ❑ Yes Pain, tenderness or noise in either jaw?
❑ No ❑ Yes Frequent headaches?
❑ No ❑ Yes Neck/shoulder pain?

❑ No ❑ Yes Frequent sore throats?
❑ No ❑ Yes Mouth breathing?
❑ No ❑ Yes Snores during sleep?
❑ No ❑ Yes Requires premedication?_____
❑ No ❑ Yes Any missing or extra permanent teeth?
❑ No ❑ Yes Apprehensive about dental care?
❑ No ❑ Yes Frequently Chew Gum?

If any of the above dental questions were answered 'Yes', please explain:

❑ No ❑ Yes Brush teeth daily?
❑ No ❑ Yes Floss teeth daily?
❑ No ❑ Yes Fluoride treatments?

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Medical History

Physician Name: | City: | State: | Date of last physical:

Address: | State: | Zip:

Patient Health:

List any medications currently being taken by the patient:

List any drug allergies or sensitivities that the patient may have:

Please select YES if the patient has had any of the conditions listed below either now or in the past.

❑ No ❑ Yes Rheumatic Fever
❑ No ❑ Yes Tuberculosis/Lung Disease
❑ No ❑ Yes Pneumonia
❑ No ❑ Yes Liver Disease
❑ No ❑ Yes Kidney Disease
❑ No ❑ Yes Heart Attack/Stroke
❑ No ❑ Yes Heart Disease
❑ No ❑ Yes Congenital Heart Defect
❑ No ❑ Yes Heart Murmur
❑ No ❑ Yes Hemophilia
❑ No ❑ Yes Hypertension/High Blood Pressure
❑ No ❑ Yes Prolonged Bleeding/Transfusion
❑ No ❑ Yes Anemia
❑ No ❑ Yes HIV/AIDS
❑ No ❑ Yes Hepatitis
❑ No ❑ Yes Tonsils/Adenoids Removed

❑ No ❑ Yes Cancer
❑ No ❑ Yes Family History of Cancer
❑ No ❑ Yes Received Radiation Treatment
❑ No ❑ Yes Growth Problems
❑ No ❑ Yes Endocrine Problems
❑ No ❑ Yes Hormone Therapy
❑ No ❑ Yes Latex/Metal Allergy
❑ No ❑ Yes Nervous Disorders
❑ No ❑ Yes Bone Disorders/Bone Loss
❑ No ❑ Yes Diabetes
❑ No ❑ Yes Seizures/Epilepsy
❑ No ❑ Yes Handicaps/Disabilities
❑ No ❑ Yes Asthma
❑ No ❑ Yes Arthritis
❑ No ❑ Yes Treated for Emotional Problems
❑ No ❑ Yes Ever Been Hospitalized

If any of the above medical questions were answered 'Yes' , please explain:

Patients Under 18

Please list the name and birth date of any siblings:

Height:	Weight:	School:	Grade:
Father/Guardian 1 Name:			
Mother/Guardian 2 Name:	Parents are ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried		

❑ No	❑ Yes	Has patient begun puberty?:
❑ No	❑ Yes	If patient is a girl, has menstruation begun:
❑ No	❑ Yes	If patient is a boy, has their voice changed or have facial hair:
❑ No	❑ Yes	Has the patient grown in the past year or has their shoe size changed recently:
❑ No	❑ Yes	Patient's interest in treatment:
❑ No	❑ Yes	Has either biological parent ever had orthodontic treatment:

Signature: Date: