IMAGE ORTHODONTICS

WELCOME

1. TELL US ABOUT YOUR CHILD DATE _____

Name_____ I prefer to be called _____

Gender/Sex _____ Gender/Sex at Birth _____

Email address_____ Birth date_____ Social Security# _____

Home Address _____

City _____ State_____ Zip_____ Home #_____

School _____ Grade _____ Hobbies_____

2. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name_____ Relation_____ Do you have legal custody of this child? ☐ Yes ☐ No

Please list brothers / sisters with ages?_____

Who may we thank for referring you?_____ General Dentist:_____ Date of last visit:_____

Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

3. PARENTS INFORMATION

Guardian 1

Name_____ Birth Date_____ Social Security# _____

Employer_____ How long at current job?_____ Occupation_____

Work phone#_____ Home phone#_____

Guardian 2

Name_____ Birth Date_____ Social Security# _____

Employer_____ How long at current job?_____ Occupation_____

Work phone#_____ Home phone#_____

4. INSURANCE INFORMATION

Primary

Insured's Name_____ Insured's SS#_____

Insurance Company_____ Group #_____ Phone_____

Insured's Employer_____ Insured's Date of Birth_____

Address of Insured_____ City_____ State_____ Zip_____

Secondary

Insured's Name_____ Insured's SS#_____

Insurance Company_____ Group #_____ Phone_____

Insured's Employer_____ Insured's Date of Birth_____

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5. MEDICAL HISTORY

What treatment goals would you like to accomplish? _____

Has your child ever been evaluated by an orthodontist? ○ Yes ○ No

Has your child ever experienced TMJ pain? ○ Yes ○ No

Has your child been informed of missing or extra permanent teeth? ○ Yes ○ No

Has your child ever taken Phen-Fen? ○ Yes ○ No

Has your child ever taken Fosomax or any other bisphosphonate? ○ Yes ○ No

Have adenoids or tonsils been removed? ○ Yes ○ No

Has your child ever injured his/her mouth, chin or teeth? ○ Yes ○ No

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

Does your child floss his/her teeth daily? ○ Yes ○ No

Is your child currently under the care of a physician? ○ Yes ○ No Please explain:_____

Physician's Name_____ Phone #:_____ Date of Last Visit:_____

Is your child currently taking any medication? Please list each one:_____

Is your child allergic to: ☐ Latex ☐ Plastics / Metals ☐ Aspirin ☐ Penicillin ? Other_____

Has your child ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Asthma	Y N Hemophilia
Y N ADD / ADHD	Y N Cancer	Y N Hepatitis
Y N Allergies to any Drugs	Y N Congenital Heart Defect	Y N HIV+ / AIDS
Y N Allergies to Latex / Metals	Y N Convulsions / Epilepsy	Y N Kidney / Liver Disease
Y N Allergies to Plastic	Y N Diabetes	Y N Rheumatic / Scarlet Fever
Y N Any Hospital Stays	Y N Handicaps / Disabilities	Y N Sinus Problems / Difficulty Breathing
Y N Any Operations	Y N Hearing Impairments	Y N Tuberculosis (TB)
Y N Artificial Bones / Joints / Valves	Y N Heart Murmur	Y N TMJ

Please discuss any medical problems that your child has had:_____

_____

6. HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Clenching / Grinding Teeth	Y N Nail Biting	Y N Finger / Thumb Sucking
Y N Lip Sucking / Biting	Y N Nursing Bottle Habit	Y N Tongue Thrusting
Y N Mouth Breathing	Y N Speech Problems	

I understand that the information given is correct to the best of my knowledge. I also understand that where appropriate, a credit report may be obtained.

Signature_____ Date_____