IMAGINE

ORTHODONTICS

PATIENT HISTORY FORM

PATIENT INFORMATION

Today's Date: _____

First Name	Middle Initial	Last Name	
Nickname	DOB / /	Gender ❑ F ❑ M	
Address	City	State	ZIP Code

RESPONSIBLE PARTY

(Please bring your Dental Insurance Card to the Appointment)

First Name	Middle Initial	Last Name		
Relationship to Patient	DOB / /	SSN - -	Gender ❑ F ❑ M	
Address	City	State	Zip	
Email Address	Cell Phone ( )	Work Phone ( )		
Dental INS Company	Member ID	Group #	Employer	

RESPONSIBLE PARTY 2

(Please bring your Dental Insurance Card to the Appointment)

First Name	Middle Initial	Last Name		
Relationship to Patient	DOB / /	SSN - -	Gender ❑ F ❑ M	
Address	City	State	Zip	
Email Address	Cell Phone ( )	Work Phone ( )		
Dental INS Company	Member ID	Group #	Employer	

DENTIST INFORMATION

Dentist Name		Phone ( )	
Address	City	State	ZIP Code

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)

First Name	Last Name
Relationship to patient	
Phone (Cell)	Phone (Work)

REFERRALS

How did you hear about our office?
Name

16920 Wright Plaza Suite 106, Omaha, NE 68130
Phone: (402) 778-5800 Fax: (402) 778-5805

10701 South 72nd Street Suite 110, Papillion NE 68046
Phone: (402) 597-6100 Fax: (402) 597-6101

IMAGINE

ORTHODONTICS

DENTAL/MEDICAL HISTORY

What would you like to change about your smile?		
Do you have any pain now? ❑ Yes ❑ No		Do your gums bleed? ❑ Yes ❑ No
Have you ever had any serious/difficult problem Associated with previous dental work? ❑ Yes ❑ No		Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ❑ Yes ❑ No
Physician Name	Physician Phone ( )	Date of last visit
Are you currently under a doctor's care if yes, why? ❑ Yes ❑ No		
Are you Pregnant? ❑ Yes ❑ No		Are you taking any prescription drugs? ❑ Yes ❑ No
Current Medications		

Have you ever had any of the following diseases or medical problems?

Prosthesis ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No	Congenital Heart Defect ❑ Yes ❑ No	Sev./Freq. Headaches ❑ Yes ❑ No
Heart Attack ❑ Yes ❑ No	Shingles ❑ Yes ❑ No	Convulsions/ Epilepsy ❑ Yes ❑ No	High/low blood Pressure ❑ Yes ❑ No
Cancer ❑ Yes ❑ No	Fever blisters ❑ Yes ❑ No	Abnormal bleeding ❑ Yes ❑ No	Drug/alcohol abuse ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	Venereal disease ❑ Yes ❑ No	Artificial valves ❑ Yes ❑ No	Blood transfusion ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No	Ulcers/colitis ❑ Yes ❑ No	Heart surgery/ Pacemaker ❑ Yes ❑ No	Anemia/radiation ❑ Yes ❑ No
HIV+AIDS ❑ Yes ❑ No	Heart murmur ❑ Yes ❑ No	Hospital stays other Than for pregnancy ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No
Hemophilia ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	Kidney/liver Problems ❑ Yes ❑ No	Breathing difficulty ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Sinus problems ❑ Yes ❑ No	Mitral valve Prolapse ❑ Yes ❑ No	Other ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No	Scarlet fever ❑ Yes ❑ No	Artificial bones/ Joints ❑ Yes ❑ No	

ALLERGIES

Aspirin ❑ Yes ❑ No	Pain Pills ❑ Yes ❑ No	Latex ❑ Yes ❑ No	Penicillin ❑ Yes ❑ No
Antibiotics ❑ Yes ❑ No	Dental Anesthetics ❑ Yes ❑ No	Tetracycline ❑ Yes ❑ No	Other ❑ Yes ❑ No
Details			

NOTICE OF PRIVACY PRACTICES

We are dedicated to protecting your personal medical information and following all provisions required by law. You are entitled to review our complete Privacy Notice which describes how we may use and disclose your medical records while you are receiving care at Imagine Orthodontics. A laminated copy of our Notice of Privacy Practices is maintained at the reception desk and is available to you for review or to obtain a photo copy.

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Legal Guardian

Date

Doctor's Signature

Date

16920 Wright Plaza Suite 106, Omaha, NE 68130
Phone: (402) 778-5800 Fax: (402) 778-5805

10701 South 72nd Street Suite 110, Papillion NE 68046
Phone: (402) 597-6100 Fax: (402) 597-6101