HIBBERD
ORTHODONTICS

Welcome to our office!

Patient Name: _____

Prefers to be called: _____ Date of Birth: _____
Circle: Male Female Non-binary

Dentist: _____ Date of last appointment: _____

Dentist's phone and/or location: _____

What are the main orthodontic concerns? _____

_____

How did you hear about us? This is extremely helpful for us:

1.Dentist (name): _____ *2.Friend/Family (name):* _____

3.Google 4.Facebook/Instagram 5.Other: _____

<u>Account Holder information</u> *(if there are two account holders please include in guardian information section at the end of the new patient form)*

Name: _____

Relationship to patient (circle): Self Mother Father Other: _____

Address (Street address, street name, city and postal code): _____

_____

Cell Phone: _____ Home Phone: _____

Email address: _____

<u>Patient Medical History</u>

1. Has there been any previous orthodontic evaluations? Yes No
2. Has there been a recent panoramic x-ray taken? Yes No
3. Is there a history of any injuries to the head, neck or face? Yes No

If yes, please give details: _____

_____

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ORTHODONTICS

4. Have adenoids or tonsils been removed? Yes No
5. Is there a history of frequent ear infections or fevers? Yes No

   If yes, please give details: _____

   _____

6. Is there a history of any surgical procedures? Yes No

   If yes, please give details: _____

   _____

7. **Please circle if the patient has ever had any of the following medical problems?**

Abnormal Bleeding	Congenital Heart Defect	Hepatitis
Allergies to Drugs	Convulsions/Epilepsy	Heart Murmur
Allergies to Latex/Metal	Diabetes	HIV+/AIDS
Asthma	Hepatitis	Kidney/Liver Problems
Cancer	Rheumatic/Scarlet Fever	Tuberculosis (TB)
Clenching/Grinding Teeth	Nail Biting	Mouthbreathing
Lip sucking	Speech Problems	Thumb/finger sucking

8. Please give details about any allergies (food, drug, environmental etc):

   _____

9. Please include any other information about dental and health history, including any medical conditions, or long term medications:_____

   _____

10. Please include any other information that you want us to be aware of:_____

    _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes to my medical status.

Signature: _____ Date: _____

Our office is committed to meeting and exceeding the standards of infection control mandated by OSHA, the CDA, and the ADA.

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For all patients who are under 18 years old

Please include guardian information (*If there are two account holders please include second account holders information here as well).*

Guardian 1 - Name:_____

Please confirm you have legal custody of the patient? Yes No

Relationship to patient (circle): Mother Father Other:_____

Address (Street address, street name, city and postal code): _____

_____

Cell Phone: _____ Home Phone: _____

Email address:_____

Guardian 2 - Name:_____

Please confirm you have legal custody of the patient? Yes No

Relationship to patient (circle): Mother Father Other:_____

Address (Street address, street name, city and postal code): _____

_____

Cell Phone: _____ Home Phone: _____

Email address:_____