HIBBERD ORTHODONTICS

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Welcome to the Orthodontist

Today's date:_____

The benefits of a happy healthy smile are immeasurable! A beautiful smile is a wonderful asset. Our goal is to make everyones visit pleasant and educational. Please fill out information below.

Name: _____
LAST *FIRST* *MI* *MR MRS MS DR*

I prefer to be called:_____ Male Female Birthdate: ____/____/____ Age: _____

Home Address:_____
APT/ CONDO # *CITY* *POSTAL CODE*

Hm #: _____ Wk #: _____ Ext#: _____ Cell #: _____Email address: _____

Single Married Divorced Widowed Seperated

Employer: _____ How long there? _____

Employer's Address: _____

Occupation: _____ Where & when are best times to reach you? _____

Whom may we **THANK** for referring you?_____

Other family members seen by us: _____

General Dentist: _____ Last Visit Date:_____

Person Responsible for Account: _____

Billing Address: _____

Relation: _____ Wk #: _____ Ext: _____ Hm #: _____

Employer: _____

MEDICAL HISTORY:

Do you have a personal physician? Yes No Date of Last Visit: _____

Physician Name: _____ Phone #:_____

Your current physical health is: Good Fair Poor Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any Prescription / Over- the-counter drug? Yes No

Please list each one: _____

For women: Are you taking birth control pills? Yes No Are you pregnant? Yes No Week#: _____

Are you nursing? Yes No

(Continued on Back)

Have you ever had any of the following diseases or medical problems?
Please list any medical condition(s) that you have ever had: _____

Y	N	Anemia	Y	N	Heart Surgery / Pacemaker
Y	N	Asthma	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Cancer / Chemotherapy	Y	N	Hepatitis
Y	N	Congneital Heart Defect	Y	N	High / Low Blood Pressure
Y	N	Diabetes	Y	N	HIV + / AIDS
Y	N	Difficulty Breathing	Y	N	Kidney Problems
Y	N	Emphysema	Y	N	Mitral Valve Prolapse
Y	N	Epilepsy / Seizures / Fainting Spells	Y	N	Scarlet Fever
Y	N	Heart Attack / Stroke	Y	N	Severe / Frequent Headaches
Y	N	Heart Murmur	Y	N	Sinus Problems

Are you allergic to any of the following? Please write:

Aspirin	Erythromycin	Penicillin	Other
Codeine	Latex	Tetracycline	

Please list any other drugs you are allergic to: _____

What are the main concerns that you would like orthodontics to accomplish? _____
_____

Have you ever been evaluated for orthodontic treatment? Yes No
Have you ever had a serious / difficult problem associated with any previous dental work? Yes No
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No
Your current dental health is: Good Fair Poor Do you like your smile? Yes No
Do your gums ever bleed? Yes No Have you ever had an injury to your: Mouth Teeth Chin
Do you have speech problems? _____
Do you generally breathe through your mouth? Awake? Yes No Asleep? Yes No
Do you have any missing or extra permanent teeth? Yes No

- This office reserves the right to verify the credit status of potential patients and / or parents prior to extending credit for treatment fees.

- 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 this office of any changes to my medical status.

_____
Signature *Date*

Doctor's Comments _____
_____
_____
_____
_____

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