HIBBERD ORTHODONTICS
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HIBBERDORTHODONTICS.COM

Welcome to the Orthodontist

Today's date: ____________________

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below:

Child's Name: ______________ *LAST* ______________ *FIRST* ______ *MI* **Nickname:** ______________

Male Female Child's Birthdate: __/__/____ Child's Age: __________ Phone #: ______________

Child's Home Address: ______________ *APT/CONDO #* ______________ *CITY* ______________ *POSTAL CODE*

Email Address: ______________________________ Cell Phone #: ______________

Hobbies / Sports: ______________________________

Who is accompanying your child today? Name: ______________________

Do you have legal custody of this child? Yes No

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

List of brothers / sisters with age: ______________________________

General Dentist: ______________________________ Last Visit Date: __________

Parent's Marital Status: Single Married Widowed Divorced Separated

Mother's Information: Mother Stepmother Guardian Phone #: ______________

Name: ______________________________

Address (if not the same as child's): ______________________________

Employer: ______________ Email: ______________ Cell Phone #: ______________

Father's Information: Father Stepfather Guardian Phone #: ______________

Name: ______________________________

Address (if not the same as child's): ______________________________

Employer: ______________ Email: ______________ Cell Phone #: ______________

Person Responsible for Account: ______________________________

Billing Address: ______________________________

Relation: ______________ Wk #: ______________ Ext: ______ Phone #: ______________

Employer: ______________ Email: ______________ Cell Phone #: ______________

(Continued on Back)

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

____

Has your child ever been evaluated for or had orthodontic treatment before ? Yes No

Have there been any injuries to the face, mouth, teeth or chin ? Yes No

Have adenoids or tonsils been removed ? Yes No

Has your child ever had any of the following medical problems ?
Please discuss any medical problems that your child has had: ______________________________

Y N	Abnormal Bleeding	Y N	Hearing Impairment	Y N	Clenching / Grinding Teeth
Y N	Allergies to any Drugs	Y N	Heart Murmur	Y N	Lip Sucking / Biting
Y N	Allergic to Latex / Metal	Y N	Hepatitis	Y N	Mouth Breather
Y N	Asthma	Y N	HIV + / AIDS	Y N	Nail Biting
Y N	Cancer	Y N	Kidney / Liver Problems	Y N	Speech Problems
Y N	Congenital Heart Defect	Y N	Rheumatic / Scarlet Fever	Y N	Thumb / Finger Sucking
Y N	Convulsions / Epilepsy	Y N	Tuberculosis (TB)	Y N	Tongue Thrust
Y N	Diabetes				

Child's Physician: ______________________________ Phone #: ______________

Date of Last Visit: ______________ Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No Has menstruation begun? (Girls) Yes No

Please describe your child's current physical health: Good Fair Poor

Please list all drugs your child is currently taking: ______________________________

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Please list all drugs your child is allergic to: ______________________________

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Please list any other allergies your child has: ______________________________

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

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

____
Signature *Date*

Doctor's comments: ______________________________

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