NEW PATIENT FORM

HIBBERD
ORTHODONTICS

Welcome to our office!

Patient Name: _____

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

Address: _____

City:_____ Postal Code:_____

Cell Phone:_____ Home Phone:_____

Email Address: _____

Guardian #1/Account Holder (the name any receipts will be in - If different from above):

Name:_____

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

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

_____

Cell Phone: _____ Home Phone: _____

Email address:_____

Guardian #2 (if applicable)

Name:_____

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

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

_____

Cell Phone: _____ Home Phone: _____

Email address:_____

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Dentist:_____

Office Name and Address:_____

_____

Dentist's Phone #:_____

Date of last appointment: _____

What are the main orthodontic concerns? _____

_____

Medical History

Has the patient ever had an orthodontic evaluation before?	Yes	No
Has the patient had any orthodontic treatment in the past?	Yes	No
Has there been a recent panoramic x-ray taken?	Yes	No
Has the patient had any injuries to the head, neck or face?	Yes	No
Have adenoids or tonsils been removed?	Yes	No
Is there a history of frequent ear infections?	Yes	No

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

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

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

_____

Please list any prescription medication that you are currently taking:_____

_____

Please include any other information about the dental health history or any other information that you want us to be aware of:_____

_____

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:_____

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.