BIBBY ORTHODONTICS

Crafting Healthy Beautiful Smiles

ADULT PATIENT INFORMATION

Patient's name_____
Last First Middle Common

Patients Preferred Pronoun – He / She / They

Mailing Address _____
Street City Postal Code

Birth date ___/___/___ Primary phone _____ Text Y / N Work phone _____
dd/mm/year

Other Number _____ Text Y / N E-mail_____

Employer_____ Occupation _____

Please list some of your hobbies/interests_____

Spouse or other Responsible Party's Name _____
Last First

Primary Phone _____ Relationship to Patient _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Plan Holder 1_____ Insurance Company_____

Plan or Group No._____ Insured's ID #_____ Employer _____

Plan Holder 2_____ Insurance Company_____

Plan or Group No._____ Insured's ID #_____ Employer _____

DENTAL HISTORY

What concerns do you have with your face, teeth, smile or bite? _____

_____

General Dentist_____ Date of last visit _____

How frequent are your routine dental visits? _____

Please circle Yes or No (If Yes, fill in details)

Yes No Are you currently experiencing any dental pain?_____
Yes No Have you ever experienced an unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth, tonsils or adenoids been removed? _____

Yes No Do you have any permanent missing teeth? If so, where & cause? _____
Yes No Have there been any injuries to your face, mouth, or teeth?_____
Yes No Have you ever lost or chipped any permanent teeth?_____
Yes No Have your teeth changed in the past 5 years? If so, how?_____
Yes No Are any of your teeth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do your gums bleed when you brush or floss? _____
Yes No Have you had or do you have gingivitis or gum disease?_____
Yes No Any history of a thumb or tongue habit? If so, when was it discontinued? _____
Yes No Any speech concerns or past / present speech language therapy ?_____
Yes No Are you a mouth breather?_____
Yes No Do you have any nasal obstructions, snoring or sleep apnea?_____
Yes No Have you ever seen an Orthodontist? If yes, who and when? _____
Yes No Are you willing to wear braces or appliances to improve your smile & bite function? _____
Yes No Has anyone in your family received orthodontic treatment?_____
How did they feel about the result? _____
Yes No Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____
Yes No Are you aware of your jaw clicking or popping? If yes, how often?_____
Yes No Do you have any problems/pain when chewing gum or hard foods (eg. Bagels)? _____
Yes No Are you aware of clenching your teeth during the day?_____
Yes No Have you ever been told that you grind your teeth at night?_____
Yes No Do you have “tension” headaches or migraines? _____
Yes No Do you experience chronic ringing in your ears? _____
Yes No Are you sensitive or self-conscious about the appearance of your teeth? _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
City _____ Phone_____

Yes No Have you seen a physician in the last 12 months? Why? _____
Yes No Are you currently taking any medication? _____
Yes No Have you had a major illness or injury?_____
Yes No Have you had your tonsils/adenoids removed? _____
Yes No Do you currently or have you ever smoked cigarettes, chewed tobacco or vaped? _____
If currently smoking, how many per day? _____

Female Patients only:

Yes No Are you, or could you be pregnant?_____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Congenital Heart Defect	Hepatitis	Pain/Pressure in Chest
ADHD	Depression	Herpes /Cold Sores	Pneumonia
Anxiety	Diabetes	High Blood	Radiation/Chemotherapy
Anemia	Dizziness	HIV / Aids	Rheumatic Fever
Arthritis	Epilepsy	Kidney problems	Seasonal Affective Disorder
Asthma	Fainting Spells	Learning Disabilities	Shortness of Breath
Autism / Spectrum	Gastrointestinal Disorders	Mouth Ulcers	Sleep Disorder
Bipolar Disorder	Hay fever	Nervous Disorders	Thyroid Trouble
Bone Disorders	Heart Murmur	Nickel Allergy	Tuberculosis
Bulimia / Anorexia	Heart Problems	OCD	Tumor or Cancer

Please list all current medications and dosage.

_____
_____
_____

Have you ever been advised you should take antibiotics prior to dental visits?_____

Have you ever or do you currently take Bisphosphonates? (Eg. Fosomax)_____

If yes, for how long, or when?_____

Do you have any medical conditions not covered above?_____
_____
_____

Have you ever been sick from, shown an allergy to, or been told not to take:

Y / N - Antibiotics (Penicillin, Erythromycin)_____
Y / N – Latex _____
Y / N - Aspirin / Ibuprofen/ Codeine _____
Y / N - Dental Anesthetic _____
Y / N – Nickel_____

Please list any other medications you may have an allergy or sensitivity to _____

EMERGENCY CONTACT INFORMATION

Name of an Emergency Contact Person_____ Relationship_____

Address_____ Phone: _____

I authorize Dr. Bibby to perform a complete orthodontic evaluation and to take diagnostic records, including photos and radiographs, as necessary for a complete diagnosis. I hereby state that I have answered all questions truthfully and to the best of my ability.

Signature:_____Date: _____

RELEASE OF INFORMATION

I agree to the sharing of records/information as indicated in regard to patient care and treatment in accordance with the Freedom of Information and Protection of Privacy Act. Such records may include dental history & treatment, medical history & treatment, prescriptions, x-rays, models, copies of dental records and medical records, insurance information, and payments. Recipients of this information are to be medical and dental professionals, their office staff, and insurance companies.

Signed_____ Date _____

Relationship to patient:
Parent, Self, Grandparent, Guardian or Specify _____