BIBBY ORTHODONTICS

Crafting Healthy Beautiful Smiles

YOUTH 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 _____ Other Number _____ Text Y / N
dd/mm/year

E-mail_____ Patient's School _____

Siblings and ages (if any)_____

Sports/Hobbies_____

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

RESPONSIBLE PARTY INFORMATION

Parent's Name _____ Relationship to Patient _____
Last First

Mailing Address (if different from above)_____
Street City Postal Code

Primary phone _____ Text Y / N Work phone _____

Cell/other phone _____ Text Y / N Email _____

Employer_____ Occupation_____

Parent's Name _____ Relationship to Patient _____
Last First

Mailing Address (if different from above)_____
Street City Postal Code

Primary phone _____ Text Y / N Work phone _____

Cell/other phone _____ Text Y / N Email _____

Employer_____ Occupation_____

Are Parents together Y / N If No is there a Custodial agreement in place? _____

Are there any additional persons responsible for this patient (ie: Step-parent, Grandparent)?_____

Relationship to Patient? _____

Contact Information_____

DENTAL INSURANCE INFORMATION

Plan 1 Holder_____ Relationship to Patient _____ Insured's ID #_____

Plan or Group No._____ Insurance Co_____ Employer _____

Plan 2 Holder_____ Relationship to Patient _____ Insured's ID #_____

Plan or Group No._____ Insurance Co_____ Employer _____

DENTAL HISTORY

General Dentist_____ Date of last visit _____

What concerns do you (or the patient) have with their face, teeth, smile or bite? _____

Frequency of routine dental visits?_____

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

Yes No Is the patient currently in any dental pain_____
Yes No Has the patient ever experienced any unfavorable reaction to dentistry?_____
Yes No Any injuries to the patient's face, mouth, or teeth? When & what type?_____
Yes No Does the patient have any missing permanent teeth? If so, where? _____
Yes No Has the patient ever lost or chipped any permanent teeth?_____
Yes No Is any part of the patient's mouth sensitive to temperature? Where?_____
Yes No Is any part of the patient's mouth sensitive to pressure? Where? _____
Yes No Do the patient's gums bleed when brushing or flossing?_____
Yes No Any history of a thumb or tongue habit? If so, when was it discontinued? _____
Yes No Is the patient a mouth breather? _____
Yes No Are there any speech concerns or past/present speech language therapy?_____
Yes No Does the patient have any nasal obstructions, snoring or sleep apnea?_____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Is the patient willing to wear braces or appliances to improve their smile & bite function? _____
Yes No Has anyone in the family received orthodontic treatment? _____
Yes No How did they feel about the result? _____
Yes No Do the patient's teeth or jaws ever feel uncomfortable in the morning? _____
Yes No Does the patient experience jaw clicking or popping? If yes, how often? _____
Yes No Do you have any problems or pain when chewing gum or hard foods? (e.g. Bagels)? _____
Yes No Are you aware of the patient clenching or grinding teeth during the day or night? _____
Yes No Does the patient experience "tension" headaches or migraines?_____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? If so, are verbal or written instruction best?_____
Yes No Is the patient sensitive or self-conscious about his/her teeth or appearance? _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

City_____ Phone _____

Patient's height _____ Patient's weight _____

Yes No Is the patient allergic to any medication? Please List _____
Yes No Has the Patient had a major illness or injury?_____
Yes No Any history of Ear/Nose/Throat infections? _____
Yes No Has the patient had any operations?_____
Yes No Has the patient had tonsils/adenoids removed? _____
Yes No Ever been involved in a serious accident? When? _____
Yes No Does the patient smoke, chew &/or vape tobacco? If so, how many times per day?_____

Female Patients only:

Yes No Has menstruation started? _____
Yes No Is the patient pregnant?_____

Male Patients only:

Yes No Has Puberty occurred (i.e. change of voice) _____

Height of parents? _____

Circle any of the medical conditions below that the patient has had in the past or currently has:

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

Are there any medical conditions we have not covered above?_____
_____

Please list all current medications and dosage: _____
_____
_____

Has the patient ever been advised they should take antibiotics before dental visits?_____

Has the patient ever been sick from, have an allergy to, or been told not to take any of the following:

Y / N - Antibiotics (Penicillin, Erythromycin)_____ Y / N - Dental Anesthetic _____

Y / N – Latex _____ Y / N – Nickel_____

Y / N - Aspirin / Ibuprofen/ Codeine _____

EMERGENCY INFORMATION

Name of Emergency Contact Person (not living with the patient)_____

Complete address_____
Street City Postal Code

Phone _____ Alt Phone _____

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

Parent / Guardian Signature: _____ Date: _____

RELEASE OF INFORMATION

I agree to the sharing of records/information as indicated in regard to patient care and treatment. 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 _____