

WELCOME TO THE OFFICE OF DR. JEFF HIBBARD!!!

IF YOU HAVE ANY QUESTIONS, PLEASE, FEEL FREE TO ASK.

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Patient's Name: _____ SS#: _____
Last First Middle

Home Phone: _____ Work Phone: _____ Drivers License#: _____ DOB: _____

Email: _____

Complete Address: _____

If Patient is a minor, give parent's/guardian's name: _____

If Patient is a full-time student, give school name: _____

Name of nearest relative not living with you: _____ Relationship: _____

Complete Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: S M D W
Last First Middle Please circle one

Social Security #: _____ DOB: _____ Relationship to patient: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse's Name: _____ Relationship to patient: _____
Last First Middle

Social Security #: _____ DOB: _____

Employer: _____ Occupation: _____ Work Phone: _____

Please continue to the other side.

INSURANCE INFORMATION

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group No.: _____

Insurance Co. Address: _____ Ph. #: _____

Is policy connected with your union? Yes ___ No ___ Name of Union: _____ Local No.: _____

Do you have dual coverage? Yes ___ No ___ If yes: Please complete the following secondary insurance information.

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group No.: _____
Local No.: _____

Insurance Co. Address: _____ Ph. #: _____

Insured's Employer: _____ Ph. #: _____

DENTAL INFORMATION

Is there anything about your teeth you would like to change? _____

Do you avoid eating certain types of food? Yes ___ No ___

Do your gums bleed when you brush? Yes ___ No ___

Are you in pain now? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure? Yes ___ No ___ Sweets? Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you feel pain or discomfort in your jaw? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

When was your last dental visit? _____

What was done at last dental visit? _____

How would you describe your current dental problem? _____
