ROBINSON
ORTHODONTICS
for children & adults

ADULT ORTHODONTIC PATIENT INFORMATION

Date_____

Patient's Name_____ Preferred Name _____

Male____ Female____ Age____ Birthdate_____ Phone _____
Month Day Year

Address_____
Street City State Zip

E-mail Address _____

___ Single ___ Married ___ Divorced ____ Children(names & ages)_____

Employed by _____ Occupation _____ No. of Yrs _____

Spouse's Name _____ Spouse's Employer _____

No of Yrs. Employed _____ Occupation _____ Work phone _____

General Dentist_____ Family Physician _____

How did you hear about our office? _____

Do you have any relatives that were treated here? _____

Main reason(s) for seeking orthodontic treatment _____

_____

Patient's hobby or special interest _____

NAME OF RESPONSIBLE PARTY FOR ACCOUNT _____

Relationship to the patient _____

Address_____
Street City State Zip

No. of years at this address? _____ Previous address (if less than 3 yrs.) _____

Work phone _____ Social Security # _____

Employed by _____ Occupation _____ No. of Yrs _____

Is the patient covered by orthodontic insurance? _____ Primary insured's DOB _____

Primary Insurance Co. _____ Policy No. _____

Insurance Co. telephone _____

Secondary Insurance Co. _____ Policy No. _____

Insurance Co. telephone _____

Medical History

Are you in good health? **Yes No** Explain: _____

Do you have any major or unusual illnesses? **Yes No** Explain: _____

Are you currently under the care of a physician? **Yes No** Reason: _____

Do you have any allergies? **Yes No** List: _____

Do you have any drug sensitivities? **Yes No** List: _____

Please list all medications that you are taking and the reason(s) for taking them _____

_____

Please indicate if you have or have ever had any of the following:

Yes	No		Yes	No		Yes	No	
___	___	Anemia	___	___	Heart problems	___	___	Frequent colds or flu
___	___	Blood disease	___	___	Tuberculosis	___	___	Are you in a risk group for AIDS
___	___	Prolonged bleeding	___	___	Diabetes	___	___	Positive test for HIV
___	___	Jaundice	___	___	Endocrine disorder	___	___	Glaucoma
___	___	Rheumatic Fever	___	___	Bone disorder	___	___	Asthma
___	___	Scarlet Fever	___	___	Epilepsy	___	___	Osteoporosis
___	___	Hepatitis	___	___	Herpes	___	___	TMJ disorder: Any tx? _____

Dental History

Yes No

___ ___Do you see a dentist regularly?

___ ___Have you had any severe head or facial injuries? Explain: _____

___ ___Have you consulted with an orthodontist previously?

___ ___Have you had any previous orthodontic treatment? Explain: _____

___ ___Do you Smoke? How much per day_____ How many years _____

___ ___Have you taken or do you take bisphosphonates (osteoporosis medication)

Please check if there is a history of:

____ Jaw joint popping _____ Jaw joint clicking ____ Jaw joint pain/soreness _____ Frequent headaches

____Grinding teeth ____ Clenching teeth ____ Ringing in the ears ____ Head or neck muscle soreness

Is there any other info about you that may be important for us to know? _____

_____

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

Signed: _____ Date: _____