ROBISON
ORTHODONTICS

ALOHA! PLEASE FILL OUT THIS FORM.

1. PATIENT INFORMATION

Name _____ _____
First MI Last Nickname

Sex _____ Phone _____ Birthday _____ Age _____

Address _____

City _____ Zip _____

2. RESPONSIBLE PARTY INFORMATION

FATHER/GUARDIAN or SELF (if Adult Patient) INFO

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Phone _____Work _____ Cell _____

Birthday _____ Age _____

Driver's License # _____ S.S.# _____

How long at this address? _____ How long at previous address? _____

MOTHER/SPOUSE INFORMATION

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Phone _____Work _____ Cell _____

Birthday _____ Age _____

Driver's License # _____ S.S.# _____

How long at this address? _____ How long at previous address? _____

Are the Patient's Parents Married? Y N

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip _____

# of Years Employed _____ Occupation _____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____ Ext _____

Group # _____

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip _____

# of Years Employed _____ Occupation _____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____ Ext _____

Group # _____

3. OTHER INFORMATION

Who is the Responsible Party? _____

Other Children _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Dentist Name _____

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

School Name _____ Grade _____

Sports or Hobbies _____

_____

Emergency Contact _____
Name Phone #

GILBERT/QUEEN CREEK 1355 South Higley Rd., Suite 105 Gilbert, Arizona 85236 T: 480.888.7711
MESA 1635 North Greenfield Rd., Suite 103, Mesa, Arizona 85205 T: 480.615.8888

PATIENT NAME _____

4. MEDICAL INFORMATION

YES	NO		YES	NO		YES	NO	
____	____	Heart Disease	____	____	History of Fainting or Dizziness	____	____	Latex Allergy
____	____	Respiratory Disease	____	____	Nervous/Emotional Problems	____	____	Nickel (Metal) Allergy
____	____	Blood Disease	____	____	Does the Patient Smoke	____	____	Tuberculosis
____	____	Thyroid Disease	____	____	Drug Addiction	____	____	Diabetes
____	____	Kidney Disease	____	____	Is the Patient Pregnant	____	____	Chemical Dependence
____	____	HIV/AIDS	____	____	Measles/Mumps/Chicken Pox	____	____	Hemophilia
____	____	Intestinal Disease	____	____	High/Low Blood Pressure	____	____	Asthma or Hay Fever
____	____	Bone Disease	____	____	Is Height and Weight Normal	____	____	Rheumatism or Arthritis
____	____	Allergic to Anything	____	____	Has Patient Reached Puberty	____	____	Tumors or Cancer
____	____	Endocrine Disease	____	____	Heart Murmur	____	____	Radiation Therapy
____	____	Liver Disease	____	____	Heart Valve Problems			
____	____	Prolonged Bleeding	____	____	Hepatitis	List any Medications the Patient is Taking		
____	____	Is Patient Under Medical Care	____	____	Anemia	_____		
____	____	Is Patient in Good Health	____	____	Epilepsy	_____		

Please List any Problems Not Mentioned that we Should Know About

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_____

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5. DENTAL HISTORY

YES	NO		YES	NO	
____	____	Has the Patient Seen a General Dentist in the Last Year	____	____	Fingernail Biting
____	____	Any Pain, Clicking or Discomfort in or Near the Ears (Jaw Joints)	____	____	Speech Problem or Speech Therapy
____	____	Has the Mouth, Face or Teeth Been Injured by a Fall or Accident	____	____	Clenching or Grinding Teeth
____	____	Have you Been Informed of Missing or Extra Permanent Teeth	____	____	Tongue Thrusting
____	____	Are You Aware of Any "Gum" Problems	____	____	Has the Patient Been Examined by an Orthodontist Before
____	____	Have the Patient's Tonsils or Adenoids Been Removed			If Yes, When _____
____	____	Thumb or Finger Sucking (Past Age 5)	____	____	Have Other Members of the Family had Orthodontic Treatment
____	____	Mouth Breathing	____	____	Are You Happy About Your Teeth and Smile

What would you like to improve about your teeth and smile? _____

How do you feel about wearing braces or Invisalign? _____

Any Questions for Dr. Robison? _____

I understand that the information I have given on this form is accurate and that I am obligated to inform Dr. Robison immediately if any information changes in the future. I understand that where appropriate, credit reports ("soft inquiry") may be obtained.

Signature of Patient or Parent/Guardian if patient is a minor _____ Date _____

6. FOR OFFICE USE

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THANKS FOR THE INFORMATION!