



**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 \_\_\_\_\_

Home # \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Birthday \_\_\_\_\_

Driver's License # \_\_\_\_\_ S.S.# \_\_\_\_\_

How long at this address? \_\_\_\_\_ How long at previous address? \_\_\_\_\_

Would you like text message appointment reminders? 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 # \_\_\_\_\_

#### MOTHER/SPOUSE INFORMATION

Name \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Birthday \_\_\_\_\_

Driver's License # \_\_\_\_\_ S.S.# \_\_\_\_\_

How long at this address? \_\_\_\_\_ How long at previous address? \_\_\_\_\_

Text Message? Y N 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 # \_\_\_\_\_

### 3. OTHER INFORMATION

Who is the Responsible Party? \_\_\_\_\_ DOB \_\_\_\_\_

Other Children \_\_\_\_\_ Date of Birth \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

Dentist Name \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

School Name \_\_\_\_\_ Grade \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_

Name Phone #

PATIENT NAME \_\_\_\_\_

### 4. MEDICAL INFORMATION

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

Please List any Problems Not Mentioned that we Should Know About  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FO \_\_\_\_\_ FC \_\_\_\_\_ TC \_\_\_\_\_ Dr. \_\_\_\_\_

THANKS FOR THE INFORMATION!

GILBERT 1355 South Higley Rd., Suite 105 Gilbert, Arizona 85296 T: 480.888.7711

MESA 1635 North Greenfield Rd., Suite 103, Mesa, Arizona 85205 T: 480.615.8888