ROBISON
ORTHODONTICS

ALOHA! PLEASE FILL OUT THIS FORM.

1. PATIENT INFORMATION

Name _____ _____
First MI Last Nickname

Sex _____ Phone _____ Birthday _____ Age _____

Address _____

City _____ Zip _____

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

2. RESPONSIBLE PARTY INFORMATION

PARENT/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

PARENT 2/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

INSURANCE/EMPLOYER INFORMATION

Employer Name _____

# of Years Employed _____ Occupation _____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Phone _____ Ext _____

Identification # _____

INSURANCE/EMPLOYER INFORMATION

Employer Name _____

# of Years Employed _____ Occupation _____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Phone _____ Ext _____

Identification # _____

3. OTHER INFORMATION

Who is the Responsible Party? _____

Other Children _____ Age _____

_____ Age ___ _____ Age ___

_____ Age ___ _____ Age ___

_____ Age ___ _____ Age ___

Dentist Name _____

School Name _____ Grade _____

Hobbies/Interests _____

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

_____

Emergency Contact _____
Name Phone #

OVER

PATIENT NAME _____

4. MEDICAL INFORMATION

YES/NO		YES/NO		YES/NO		YES/NO	
____ ____	Is Patient Under Medical Care	____ ____	Epilepsy	____ ____	Hepatitis	____ ____	Tumors or Cancer
____ ____	Is Patient in Good Health	____ ____	Endocrine Disease	____ ____	Anemia	____ ____	Radiation Therapy
____ ____	Heart Disease	____ ____	Liver Disease	____ ____	Allergic to Anything		
____ ____	Respiratory Disease	____ ____	Prolonged Bleeding	____ ____	Latex Allergy	Please List any Problems Not Mentioned that we	
____ ____	Thyroid Disease	____ ____	History of Fainting or Dizziness	____ ____	Nickel (Metal) Allergy	Should Know About	
____ ____	Kidney Disease	____ ____	Nervous/Emotional Problems	____ ____	Tuberculosis	_____	
____ ____	HIV/AIDS	____ ____	Does the Patient Smoke	____ ____	Diabetes	_____	
____ ____	Intestinal Disease	____ ____	Is the Patient Pregnant	____ ____	Asthma or Hay Fever	_____	
____ ____	Bone Disease	____ ____	High/Low Blood Pressure	____ ____	Rheumatism or Arthritis	_____	

List any medication the patient is taking or other medical concerns we should be aware about

_____

_____

_____

5. DENTAL HISTORY

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

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

_____

_____

_____

_____

_____

TC _____ Dr. _____

THANKS FOR THE INFORMATION!

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