ROBERT T. ROBINSON, D.D.S.

SPECIALIST IN CHILD/ADULT ORTHODONTICS

CHILD FORM

PATIENT'S NAME_____ DATE_____

STREET_____ PHONE_____

CITY AND ZIP CODE_____

AGE_____ DATE OF BIRTH_____ SEX_____

REFERRED BY_____

DENTIST_____ PHYSICIAN_____

FATHER'S NAME_____FATHER'S CELL _____

FATHER'S EMAIL_____

OCCUPATION_____BUSINESS PHONE_____

BUSINESS ADDRESS_____

MOTHER'S NAME_____MOTHER'S CELL_____

MOTHER'S EMAIL_____

OCCUPATION_____BUSINESS PHONE_____

BUSINESS ADDRESS_____

MARITAL STATUS OF PARENTS_____

PERSON FINANCIALLY RESPONSIBLE_____

ADDRESS_____ PHONE_____

OTHER CHILDREN IN FAMILY AND AGES_____

REASON FOR ORTHODONTIC CONSULTATION_____

HAS ANYONE IN FAMILY HAD A SIMILAR PROBLEM?_____

NAMES AND AGES OF ANYONE IN FAMILY WHO HAS HAD ORTHODONTIC

TREATMENT_____

DATE TREATED AND BY WHOM?_____

IS PATIENT SELF-CONSCIOUS ABOUT HIS/HER TEETH?_____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT_____

PATIENT'S INTERESTS AND HOBBIES_____

SPORTS_____MUSICAL INSTRUMENTS_____

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MEDICAL HISTORY

PRESENT STATE OF HEALTH__EXCELLENT ___GOOD ___FAIR ___POOR

IS PATIENT CURRENTLY UNDER A PHYSICIAN'S CARE?_____

DATE OF LAST MEDICAL EXAM_____ DENTAL EXAM_____

LIST ANY ALLERGIES OR DRUG SENSITIVITIES_____

HAVE TONSILS OR ADENOIDS BEEN REMOVED?_____

CHECK THE FOLLOWING WHERE APPLICABLE TO THE PATIENT:

___Asthma	___Rheumatic Fever	___Hearing Disorders
___Epilepsy	___Heart Problems	___Bleeding Disorders
___Diabetes	___X-Ray Therapy	___Vision Impairment
___Hepatitis	___Emotional Problems	

LIST ANY OTHER ILLNESSES, ACCIDENTS AND/OR HOSPITALIZATIONS___

_____

_____

DENTAL HISTORY

LIST ANY INJURIES TO TEETH, MOUTH OR FACE_____

HAS PATIENT HAD: ___Previous Dental Treatment, __Regular Dental Checkups, ___Extractions, __X-Rays, ___Orthodontic Consultations?

INDICATE HABITS, PAST OR PRESENT, RELATING TO MOUTH OR FACE:

___Thumb (Finger) Sucking	___Tooth Grinding/Clenching
___Tongue Thrust (Reverse Swallowing)	___Sleeping Habits (Blanket Sucking)
___Poor Speech Habits	___Chewing Habits
___Mouth Breathing	___Lip Biting
___Nail Biting	___Other:_____

INSURANCE INFORMATION

PLEASE CHECK WITH YOUR DENTAL INSURANCE CARRIER TO SEE IF YOU ARE ELIGIBLE FOR ORTHODONTIC COVERAGE. IF TREATMENT IS DESIRED, PLEASE BRING IN A CLAIM FORM AND WE WILL ASSIST YOU IN PROCESSING IT.

SIGNED_____ DATE_____

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