ROBERT T. ROBINSON, D.D.S.
SPECIALIST IN CHILD/ADULT ORTHODONTICS

ADULT FORM

In order to perform a more complete service for our patients, we ask your cooperation in completing this questionnaire.

NAME_____ DATE_____

STREET_____ PHONE_____

CITY AND ZIP CODE_____

AGE_____ DATE OF BIRTH_____ SEX_____

REFERRED BY_____

DENTIST_____ PHYSICIAN_____

CELL PHONE_____EMAIL_____

OCCUPATION_____

BUSINESS ADDRESS_____PHONE_____

MARITAL STATUS_____ SPOUSE'S NAME_____

SPOUSE'S CELL_____SPOUSE'S EMAIL_____

SPOUSE'S OCCUPATION_____

BUSINESS ADDRESS_____PHONE_____

PERSON FINANCIALLY RESPONSIBLE_____

REASON FOR ORTHODONTIC CONSULTATION_____

HAS ANYONE IN FAMILY HAD A SIMILAR PROBLEM?_____

HAS ANYONE IN FAMILY HAD ORTHODONTIC TREATMENT?_____

IF YES, NAMES_____

YOUR INTERESTS AND HOBBIES_____

SPORTS_____ MUSICAL INSTRUMENTS_____

PRESENT STATE OF HEALTH_____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE?_____

ARE YOU TAKING ANY MEDICATION?_____

DATE OF LAST MEDICAL EXAM_____

Please continue on other side

MEDICAL HISTORY

LIST ANY ALLERGIES OR DRUG SENSITIVITIES_____

HAVE TONSILS OR ADENOIDS BEEN REMOVED?_____

CHECK THE FOLLOWING WHERE APPLICABLE TO THE PATIENT:

__Asthma	___Chickenpox	___Emotional Problems
___Measles	___Polio	___Hearing Disorders
___Mumps	___Hepatitis	___Bleeding Disorders
___Epilepsy	___Rheumatic Fever	___Vision Impairment
___Diabetes	___Heart Problems	___X-Ray Therapy

LIST ANY OTHER ILLNESSES, ACCIDENTS AND/OR HOSPITALIZATIONS___

_____

Do you have headaches?___ Neck pains?____Jaw Pain?____ Ear Pain?____ Face Pain?____
Eye Pain?___ Others?_____
Which side hurts? Right_____ Left_____ Both_____
How long have you had these symptoms? Years_____ Months_____ Days_____
Is the pain constant?____ Aching?____ Shooting?____ Burning?____ Stabbing?____ Electrical?____
Other?_____
Worse in the morning?_____ Worse in the afternoon?_____
Does it hurt to chew?_____ Open wide?_____
Does your jaw make a popping noise?____ Clicking?____ Grinding?____ Other?____
Has your jaw ever "locked" or slipped out of place?_____
Do you ever clench or grind your teeth?____ During the day____ At night____
Do you have problems with your ears?____ Hearing?____ Dizziness?____ Other?____
Is it difficult to swallow?_____ Painful?_____
Are your teeth sore or sensitive?_____

DENTAL HISTORY

LIST ANY INJURIES TO TEETH, MOUTH OR FACE_____

HAVE YOU 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_____