ROBERT T. ROBINSON, DDS
New Providence Orthodontics

Today's Date_____

PATIENT INFORMATION FORM

Patient's Name_____ Date of Birth_____ Age_____ Sex_____

Address_____City/State/Zip _____

Cell _____ Other Phone # _____ Email _____

Referred By _____ Dentist_____ Physician_____

Date of last Dental Exam _____

Patient's Occupation *(if applicable*) _____ Business Name: _____

Patient's interests & Hobbies _____

Sports_____ Musical Instruments _____

If patient is 18 years of age or* under** *please complete this section,** *otherwise please continue to the next section.*

Father's Name _____ Cell _____ Email _____

Father's Occupation _____ Business Name _____

Mother's Name _____ Cell _____ Email _____

Mother's Occupation_____ Business Name _____

Parent('s) Marital Status: Married_____ Divorced_____ Widowed_____

ORTHODONTICS INFO

Reason for Orthodontic Consultation_____

Has anyone in family had a similar problem?
_____

Has anyone in the Family had orthodontic treatment? Yes | No If Yes, please enter information below:

Names _____ Date Treated? _____ Orthodontist _____

Names _____ Date Treated? _____ Orthodontist _____

Patient's attitude toward orthodontics_____

Is patient self-conscious about their teeth? _____

Please continue on the other side

MEDICAL & DENTAL HISTORY

Is patient in good health?_____ Date of last medical exam _____
Is patient under physicians care?_____ If yes, please indicate as to why_____
Medication(s) taking _____
List any allergies or drug sensitivities _____
Have tonsils or adenoids been removed? _____

Check the following where applicable to the patient

____Asthma	____Hepatitis	_____Vision impairment
____Diabetes	____Heart Problems	_____X-ray therapy
____Epilepsy	____Hearing disorders	_____Emotional problems
____Bleeding disorders		

Please list any other illness/issues/accidents and or hospitalizations _____

Check any that apply	Which Side? Left/Right/Both	How long? Yrs/Months/Days	Describe Pain: Aching, Shooting, Burning/Stabbing/Other	Worse in AM or PM?
Headaches				
Neck Pain				
Jaw Pain				
Ear Pain				
Face Pain				
Eye Pain				
Other				

Does it hurt to chew? _____ Open Wide? ____
Has your jaw ever locked or slipped out of place? _____
Does your jaw make a popping noise? _____ Click? _____ Other? _____
Do you clench or grind your teeth? _____ If yes, is it during the day/night/both? _____
Ear problems? _____ Hearing? _____ Dizziness?_____ Other _____
Difficulty or painful swallowing? _____ Are your teeth sore or sensitive? _____

List any injuries to teeth, mouth or face _____

Has Patient had: ____Previous Dental Treatment _____ Regular Dental Checkups _____ Extractions
____ Dental X-Rays ____Orthodontic Consultations

Habits *(past/present)* relating to Mouth or Face – *Check all that apply*

_____ Thumb (Finger) Sucking	_____ Tooth Grinding/Clenching	_____ Poor Speech Habits
_____ Blanket Sucking	_____ Chewing Habits	_____ Tongue Thrust (Reverse Swallowing)
_____ Mouth Breathing	_____ Lip Biting	_____ Nail Biting _____Other

Patient/Guardian Signature _____ Date _____