ROBINSON
ORTHODONTICS
Jon N. Robinson, DMD, MS

PATIENT INFORMATION FORM

Name _____

Welcome to our office ...
Please assist us by completing the following questions:

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING

	YES	NO		YES	NO		YES	NO
Diabetes	☐	☐	Tuberculosis	☐	☐	Endocrine or Thyroid	☐	☐
Pneumonia	☐	☐	Anemia	☐	☐	Prolonged Bleeding	☐	☐
Heart Trouble	☐	☐	Epilepsy	☐	☐	Liver Involvement	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Fainting and Dizziness	☐	☐
Bone Disorders	☐	☐	Kidney Involvement	☐	☐	Nervous Disorders	☐	☐
Hepatitis B	☐	☐	HIV/AIDS	☐	☐	Other	☐	☐

	YES	NO	?
Is the patient in good health: _____	☐	☐	☐
Does the patient have any history of major illness? _____	☐	☐	☐
List any drugs or medications now being taken. Give reasons _____			
Does the patient have arthritis? _____	☐	☐	☐
List any Allergies or drug sensitivity _____			
Does patient wear contact lenses? _____	☐	☐	☐
Have wisdom teeth been removed? What age: _____	☐	☐	☐
Has patient seen physician in last 2 years? _____	☐	☐	☐
If yes, why? _____			

Patient's Physician _____

DENTAL HISTORY

	YES	NO	?
Have there been any injuries to the face, mouth or teeth? _____	☐	☐	☐
Does the patient have any problems with their speech? _____	☐	☐	☐
Does the patient breathe predominantly through their mouth? _____	☐	☐	☐
Does the patient have frequent headaches? _____	☐	☐	☐
Has the patient had any clicking or discomfort in jaw joints near ears? _____	☐	☐	☐
Has the patient been informed of any missing or extra permanent teeth? _____	☐	☐	☐
Has the patient had any previous orthodontic examinations? _____	☐	☐	☐
Does the patient clench or grind their teeth? _____	☐	☐	☐
Has patient ever had any periodontal (gum) treatment? _____	☐	☐	☐
Does patient feel that they need orthodontic treatment? _____	☐	☐	☐
Is the patient apprehensive about orthodontic treatment? _____	☐	☐	☐
When did the patient last visit their dentist? _____ Were any x-rays taken? _____	☐	☐	☐
Would the patient mind wearing braces? _____	☐	☐	☐
List sports and interests _____			
Reason for orthodontic examination _____			

Patient's Dentist _____

_____
Signature