Welcome to the office of Drs. Brian C. and Joseph R. Dubin

Dubin Orthodontics
ESTABLISHED 1976

Adult Patient Form

Patient's Name: ____________ Nickname: ____________ Social Security#: ____________

Birthdate: ____________ ❑ Male ❑ Female Home phone: ____________ Cell: ____________

Home Address: ____________ City: ____________ State: ______ Zip code: ______

E-mail: ____________

Employer: ____________ Present Position: ____________

Business Address: ____________ Business Phone: ____________ Ext: ______

Patient's Dentist: ____________ Phone: ____________

Address: ____________ City: ____________ State: ______ Zip code: ______

Whom may we thank for this referral? ❑ Dentist: (name) ____________

❑ Friends: (name) ____________ ❑ Friends: (name) ____________

❑ Friends: (name) ____________ ❑ Other: (name) ____________

Family members who have been patients: (name & relationship) ____________

MARITAL STATUS

❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT THAN ABOVE)

Name: ____________ Social Security#: ____________

Address: (if different) ____________

Home Phone: ____________ Cell: ____________ E-mail: ____________

Employer: ____________ Present Position: ____________

Business Address: ____________ Business Phone: ____________ Ext: ______

PRIMARY DENTAL INSURANCE

Insurance Co. Name: ____________ Insurance Co. Phone: ____________

Insurance Co. Address: ____________ Group# (Plan, Local, or Policy#): ____________

____________ **Insured's** Birthday: ____________ SS#: ____________

Insured's Name: ____________ Relationship to patient: ____________

Insured's Employer: ____________ Orthodontic Coverage? ❑ Yes ❑ No

Name of Physician: ____________ Phone: ____________

Address: ____________ City: ____________ State: ______ Zip code: ______

SECONDARY DENTAL INSURANCE

Insurance Co. Name: ____________ Insurance Co. Phone: ____________

Insurance Co. Address: ____________ Group# (Plan, Local, or Policy#): ____________

____________ **Insured's** Birthday: ____________ SS#: ____________

Insured's Name: ____________ Relationship to patient: ____________

Insured's Employer: ____________ Orthodontic Coverage? ❑ Yes ❑ No

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MEDICAL HISTORY

	Please Circle			Please Circle			Please Circle	
Heart Murmur/Congenital Defect	Y	N	High Blood Pressure	Y	N	Handicaps	Y	N
Diabetes	Y	N	Convulsions/Epilepsy	Y	N	Latex Allergy	Y	N
Rheumatic Fever	Y	N	Abdominal Bleeding	Y	N	Learning Disability	Y	N
Cancer	Y	N	Hearing Impairment	Y	N	Special Needs	Y	N
HIV +/AIDS	Y	N	Operations/Stays in a Hospital	Y	N	Prolonged use of NSAIDs (Advil, Motrin, Aleve, etc.)	Y	N
Hemophilia	Y	N	Kidney/Liver Problems	Y	N			
Blood Transfusions	Y	N	Allergies to Drugs	Y	N			
Asthma	Y	N	Antibiotics Prior to Dental Treatment	Y	N			
Hepatitis	Y	N	Other Medical Conditions	Y	N			
Tuberculosis	Y	N	Medications	Y	N			
Heart Problems	Y	N	Pregnant	Y	N			
Sinus Problems	Y	N	Osteoperosis/bone condition	Y	N			

*If you have circled **Yes** for any of the above, please explain:* ______________________________

____

DENTAL HISTORY

Injuries to Face/Teeth	Y	N	Unfavorable Dental Experience	Y	N	Speech Problems	Y	N
Other Orthodontic Treatment	Y	N	Missing Teeth	Y	N	Mouth Breathing	Y	N
Pain/Noises in the Jaw Joint (TMJ)	Y	N	Extra Teeth	Y	N	Gums Bleed	Y	N
Root Resorption	Y	N	Finger Sucking	Y	N	Grind Teeth	Y	N
Periodontal Disease	Y	N	Tongue Thrusting	Y	N			

*If you have circled **Yes** for any of the above, please explain:* ______________________________

____

What do you see as the main problem with your teeth? ______________________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

______________________________ Signature

______________________________ Date

Thank you for completing this form. It will enable us to treat you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.