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



## **Adult Patient Form**

Business Address:	Patient's Name:	Nickname:	Social Security#:	
Employer:	Birthdate: □ Male □ Female	Home phone:	Cell:	
Employer:	Home Address:	City:	State:	Zip code:
Business Address:	E-mail:			
Patient's Dentist: Phone: City: State: Zip code: Address: City: State: Zip code: Address: City: State: Zip code: Morn may we thank for this referral? Dentist: (name)   Friends: (name)   Friends: (name)   Other: (name)   Other: (name)   Friends: (name)   Other: (name)	Employer:	Present Po	osition:	abdolesh
Address: City: State: Zip code: City: City	Business Address:	Business F	Phone:	Ext:
Whom may we thank for this referral?	Patient's Dentist:	Phone:		
Whom may we thank for this referral?	Address:	City:	State:	Zip code:
Friends: (name)				
Priends: (name)     Other: (name)     Other: (name)				
MARITAL STATUS    Married   Single   Widowed   Divorced   Separated				
Married   Single   Wildowed   Divorced   Separated	Family members who have been patients: (name & relationship)			<u> </u>
Married   Single   Wildowed   Divorced   Separated				
Married   Single   Wildowed   Divorced   Separated	MARITAI STATUS			
PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENTTHANABOVE)  Name:	IAM ALS IA 100	MANAGEMENTATION CONTRACTOR CONTRACTOR		
Social Security#:	☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated	1		
Social Security#:				
Address: (if different) Home Phone: Cell: E-mail:	PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT TH	HAN ABOVE)		
Address: (if different) Home Phone: Cell: E-mail:		COLUMN DE SECRETARION DE LA COLUMN DE LA COL		
Address: (if different) Home Phone: Cell: E-mail:	Name: Socia	I Security#:	graphic in a straight	
E-mail:				
Business Address:				
PRIMARY DENTAL INSURANCE  Insurance Co. Name:	Employer:	Present F	Position:	
Insurance Co. Name: Insurance Co. Phone: Insurance Co. Address: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#:  Insured's Name: Relationship to patient: Orthodontic Coverage? Yes No  Name of Physician: Phone: City: State; Zip code: SECONDARY DENTAL INSURANCE  Insurance Co. Name: Insurance Co. Phone: Insurance Co. Address: Group# (Plan, Local, or Policy#): Insurance Co. Address: Relationship to patient: SS#:  Insurance Co. Address: Relationship to patient: SS#:  Insured's Name: Relationship to patient: Relationship to patient:				
Insurance Co. Name: Insurance Co. Phone: Insurance Co. Address: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#:  Insured's Name: Relationship to patient: Orthodontic Coverage? Yes No  Name of Physician: Phone: City: State; Zip code: SECONDARY DENTAL INSURANCE  Insurance Co. Name: Insurance Co. Phone: Insurance Co. Address: Group# (Plan, Local, or Policy#): Insurance Co. Address: Relationship to patient: SS#:  Insurance Co. Address: Relationship to patient: SS#:  Insured's Name: Relationship to patient: Relationship to patient:				
Insurance Co. Name:	DRIMARY DENTAL INCLIDANCE			
Insurance Co. Address:		THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	THE RESERVE OF THE PERSON OF T	Debug and the second second second
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: Group# (Plan, Local, or Policy#): Insurance Co. Address: SS#:  Insured's Birthday: SS#:  Insured's Name: Relationship to patient:				
Insured's Name:				
Insured's Employer: Orthodontic Coverage?				Con 175
Name of Physician: Phone: State; Zip code: SECONDARY DENTAL INSURANCE  Insurance Co. Name: Insurance Co. Phone: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#:  Insured's Name: Relationship to patient: Relationship to patient: State; Zip code: Zip code: SECONDARY DENTAL INSURANCE				127
City: State; Zip code:   SECONDARY DENTAL INSURANCE   Insurance Co. Phone:   Insurance Co. Address: Group# (Plan, Local, or Policy#):   Insured's Birthday: SS#:   Insured's Name: Relationship to patient:   Insured's Description of the patient insurance Co.   State; Zip code:   Zip code:   Insurance Co. Phone:				
Insurance Co. Name: Insurance Co. Phone: Insurance Co. Address: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#:  Insured's Name: Relationship to patient:				Contract of
Insurance Co. Name: Insurance Co. Phone: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#: Relationship to patient:	Address:	City:	State:	Zip code:
Insurance Co. Address: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#: Relationship to patient:	SECONDARY DENTAL INSURANCE			
Insurance Co. Address: Group# (Plan, Local, or Policy#): Insured's Birthday: SS#: Relationship to patient:	Insurance Co. Name:	Insurance Co. Phon	ne:	
Insured's Birthday: SS#:  Relationship to patient:	engle statutes adect state of the control and			
Insured's Name: Relationship to patient:				

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## **MEDICAL HISTORY**

	Please	e Circle		Pleas	e Circle		Pleas	se Circl
Heart Murmur/Congenital Defect	Υ	N	High Blood Pressure	Υ	N	Handicaps	Υ	N
Diabetes	Υ	N	Convulsions/Epilepsy	Υ	N	Latex Allergy	Y	N
Rheumatic Fever	Υ	N	Abdominal Bleeding	Y	N	Learning Disability	Y	N
Cancer	Υ	N	Hearing Impairment	Y	N	Special Needs	Υ	N
HIV +/AIDS	Υ	N	Operations/Stays in a Hospital	Υ	N	Prolonged use of	Υ	N
Hemophilia	Υ	N	Kidney/Liver Problems	Υ	N	NSAIDs (Advil,		
Blood Transfusions	Υ	N	Allergies to Drugs	Y	N	Motrin, Aleve, etc.)		
Asthma	Υ	N	Antibiotics Prior to Dental Treatment	Y	N			
Hepatitis	Υ	N	Other Medical Conditions	Υ	N			
Tuberculosis	Υ	N	Medications	Y	N			
Heart Problems	Υ	N	Pregnant	Y	N			
Sinus Problems	Υ	N	Osteoperosis/bone condition	Υ	N			
DENTAL HISTORY	and the second			Michigan saw			a francisco	
Injuries to Face/Teeth	Υ	N	Unfavorable Dental Experience	Υ	N	Speech Problems	Υ	N
Other Orthodontic Treatment	Υ	N	Missing Teeth	Υ	N	Mouth Breathing	Y	N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ)	Y	100000	Missing Teeth Extra Teeth			Mouth Breathing Gums Bleed	Y	N N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ) Root Resorption	Y Y Y	N N N	Missing Teeth Extra Teeth Finger Sucking	Y Y Y	N	Mouth Breathing	Y	N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ)	Y	N N	Missing Teeth Extra Teeth	Y	N N	Mouth Breathing Gums Bleed	Y	N N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ) Root Resorption Periodontal Disease	Y Y Y	N N N	Missing Teeth Extra Teeth Finger Sucking Tongue Thrusting	Y Y Y	N N N	Mouth Breathing Gums Bleed Grind Teeth	Y	N N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ) Root Resorption Periodontal Disease  f you have circled Yes for any of the	Y Y Y Y	N N N N	Missing Teeth Extra Teeth Finger Sucking Tongue Thrusting	Y Y Y	N N N	Mouth Breathing Gums Bleed Grind Teeth	Y Y Y	N N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ) Root Resorption Periodontal Disease  f you have circled Yes for any of the What do you see as the main problem  I understand that the information	Y Y Y Y above, p	N N N N Iease exp ur teeth?	Missing Teeth Extra Teeth Finger Sucking Tongue Thrusting  blain:  en today is correct to the best of my know	Y Y Y Y	N N N	Mouth Breathing Gums Bleed Grind Teeth	YYY	N N N
Other Orthodontic Treatment Pain/Noises in the Jaw Joint (TMJ) Root Resorption Periodontal Disease  f you have circled Yes for any of the What do you see as the main problem  I understand that the information	Y Y Y Y above, p	N N N N Iease exp ur teeth?	Missing Teeth Extra Teeth Finger Sucking Tongue Thrusting	Y Y Y Y	N N N	Mouth Breathing Gums Bleed Grind Teeth	YYY	N N N

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.



