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

Dubin Orthodontics
ESTABLISHED 1976

Creating beautiful smiles that last a lifetime

Child Patient Form

Patient's Name: _____ Nickname: _____

Birthdate: _____ ❑ Male ❑ Female Home phone: _____

Home Address: _____ City: _____ State: _____ Zip code: _____

Special interests, sports or hobbies: _____

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) _____

Name of person accompanying child today: _____ Relationship: _____

Parents' Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

If remarried, spouse's name: _____

SIBLINGS

Name	Date of Birth	Sex	Name	Date of Birth	Sex
		❑ Male ❑ Female			❑ Male ❑ Female
		❑ Male ❑ Female			❑ Male ❑ Female
		❑ Male ❑ Female			❑ Male ❑ Female

PARENT'S INFORMATION

Mother's Name: _____ Social Security#: _____

Address: (if different) _____

Home Phone: _____ Cell: _____ E-mail: _____

Employer: _____ Present Position: _____

Business Address: _____ Business Phone: _____ Ext: _____

Father's Name: _____ Social Security#: _____

Address: (if different) _____

Home Phone: _____ Cell: _____ E-mail: _____

Employer: _____ Present Position: _____

Business Address: _____ Business Phone: _____ Ext: _____

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: _____

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PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group# (Plan, Local, or Policy#): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: _____ SS#: _____

Insured's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No

Name of Physician: _____

Address: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group# (Plan, Local, or Policy#): _____

Insured's Name: _____

Relationship to Patient _____

Insured's Birthday: _____ SS#: _____

Insured's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No

Phone: _____

City: _____ State: _____ Zip code: _____

MEDICAL HISTORY

	Please Circle			Please Circle			Please Circle	
Heart Murmur/Congenital Defect	Y	N	High Blood Pressure	Y	N	Learning Disability	Y	N
Diabetes	Y	N	Convulsions/Epilepsy	Y	N	Special Needs	Y	N
Rheumatic Fever	Y	N	Abdominal Bleeding	Y	N	ADD/ADHD	Y	N
Cancer	Y	N	Hearing Impairment	Y	N			
HIV +/AIDS	Y	N	Operations/Stays in a Hospital	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	Latex Allergy	Y	N			
Sinus Problems	Y	N	Handicaps	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.

DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

Member American Association of Orthodontists