dobie revolution
ORTHODONTICS

Hamden & Guilford Locations

(203) 288 – 0900

www.dobierevolution.com

PATIENT INFORMATION *for* ADULTS

Date: _____

Full Name: _____ Nickname: _____ Gender: _____

Date of Birth: _____ Age: _____ SSN: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Email: _____

Has anyone in your family been treated in our office? _____

Please CIRCLE how you would you like to receive appointment reminders: Email Text Message Both

Your Employer

Employer: _____

Occupation: _____

Business phone: _____

Your Spouse

Spouse's Name: _____

Spouse's Employer: _____

Cell #: _____

Date of Birth: _____

Social Security #: _____

Responsible Party Name: _____

How did you find us? Dentist Invisalign Website Google Search Social Media Friend: _____

Are you on Facebook? Yes No Please follow us: www.facebook.com/dobierevolution

Are you on Instagram? Yes No Please follow us: @dobierevolution

MEDICAL HISTORY

Please Circle All Conditions That Apply:

Heart abnormality	Diabetes	Cancer/Tumor	Hearing Impairment
Rheumatic/Scarlet fever	HIV/AIDS	GI Disorder	Speech Disorder
Artificial Heart Valve	Hepatitis	Epilepsy/Seizures	Fainting/Dizziness
High/Low Blood Pressure	Bronchitis	Autism	Nervous/Anxious
Kidney/Liver problems	Asthma	Cleft Lip/Palate	Tactile Defensive
Bleeding Abnormality	Thyroid Disorder	Birth Defect(s)	Major Surgery
Sickle Cell Anemia	Bone Disorder	Growth Disorder	Currently Pregnant
Tuberculosis	Artificial Joints	Tonsils/Adenoids removed	**NONE**

If circled, please explain: _____

Condition not listed: _____

Any allergies? Yes No Please explain: _____

Any medications? Yes No Please explain: _____

TURN OVER

DENTAL HISTORY

Have you <u>previously</u> had any:

Y	N	Abscessed permanent teeth
Y	N	Injured/chipped teeth
Y	N	Periodontal disease/treatment
Y	N	TMJ problems (clicking/pain)
Y	N	Major injuries to jaw/face
Y	N	Jaw/orthognathic surgery

Do you <u>currently</u> have any:

Y	N	Missing permanent teeth
Y	N	Dental implants
Y	N	Active dental decay/cavities
Y	N	TMJ problems (clicking/pain)
Y	N	Clenching/grinding habits
Y	N	Retainers (fixed or removable)

If yes, please explain: _____

Dentist's Name: _____ Last Dental Visit: _____

Do you currently have any planned dental treatment? Yes No Please explain: _____

_____

Any previous orthodontic treatment? Yes No If yes, at what age: _____

Any recent orthodontic consultations? Yes No If yes, how long ago: _____

What treatment was recently recommended? _____

What would you like orthodontics to accomplish? _____

_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the practice of any medical or dental changes to this record.

Patient's Signature: _____ **Date:** _____

OFFICE USE ONLY

Right: Class I Class II_____ Class III_____ X-B_____

Left: Class I Class II_____ Class III_____ X-B_____

OJ: _____ **OB**: _____ Deep _____ Open _____

Upper: Crowding _____ Spacing _____

Lower: Crowding _____ Spacing _____

Other: _____

_____

_____

Perio Clearance: Y N **Ins:** _____

Tx Plan: _____

_____

_____

_____

_____

Est. Fee: _____ **Est. Time:** _____