Dr. Nathan Rubin D.D.S.

RUBIN ORTHODONTICS
"The bridge to your perfect smile"

Dr. Robert Tzvi Rubin D.D.S.

Name _____ Date of Birth _____ Today's Date _____

GENERAL INFORMATION

Address _____ Telephone Daytime ( ) _____
_____ Zip _____ Evenings ( ) _____
Father's Name _____ Mother's Name _____
Parents' e-mail address's _____ Patient's e-mail address _____
Person Financially Responsible _____ Relationship _____
Business Address _____ Occupation _____
Responsible SS# _____ Zip _____
Insurance Covering Orthodontics _____
Dentist _____ Physician _____ Referred by _____

DENTAL/MEDICAL HISTORY

Currently under physician's care ☐ No ☐ Yes, Why? _____
Currently taking any drugs? ☐ No ☐ Yes, What? _____

HISTORY OF ANY OF THE FOLLOWING:

NO	YES		NO	YES		NO	YES	
☐	☐	AIDS	☐	☐	Emotional Disorders	☐	☐	Prosthetic Valve or Hip Replacement
☐	☐	Allergies	☐	☐	Endocrine Disorders	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Heart Defects	☐	☐	Seizures
☐	☐	Bleeding disorders	☐	☐	HIV Carrier	☐	☐	Smoking
☐	☐	Calcium deficiency	☐	☐	Hepatitis	☐	☐	Speech problems
☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐	Venereal Disease

HAS PATIENT EVER EXPERIENCED ANY OF THE FOLLOWING?

If yes, explain: _____

NO	YES	
☐	☐	History of head or neck abnormalities (e.g., cleft lip, etc.)
☐	☐	Injuries, accidents, or surgery to head or neck
☐	☐	Clicking, popping, or ringing in ears upon wide opening
☐	☐	Facial pain, headaches, stiff neck
☐	☐	Jaw locked in an open or closed position

HABITS:

NO	YES		
	Past	Present	
☐	☐	☐	Thumb/Finger Sucking
☐	☐	☐	Tongue Thrust (Reverse Swallow)
☐	☐	☐	Mouth Breathing (Snoring)
☐	☐	☐	Lip Biting
☐	☐	☐	Teeth Clenching or Grinding
☐	☐	☐	Gum Chewing

FOR CHILDREN AND ADOLESCENTS ONLY:

	Large	Avg.	Small
Patient's Size	☐	☐	☐
Mother's Size	☐	☐	☐
Father's Size	☐	☐	☐

Onset of Puberty ☐ No ☐ Yes, How long ago? _____
Is This Child ☐ Natural ☐ Adopted?
Eruption of Teeth: ☐ Early ☐ Average ☐ Late

Reason for Consultation: _____
Previous Orthodontic Consultation? ☐ No ☐ Yes Previous Orthodontic Treatment? ☐ No ☐ Yes
Are you aware of any familial or hereditary tendency towards this problem? _____
Patient's attitude toward orthodontic treatment: ☐ In Favor ☐ Indifferent ☐ Opposed
Expected patient cooperation: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Oral Hygiene Habits: ☐ Good ☐ Fair ☐ Poor Intake of Sweets: ☐ High ☐ Medium ☐ Low
Does the patient play a musical instrument? _____

I have answered these questions to the best of my ability. Signature _____

Relationship to Patient _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name of Patient or Parent/guardian of minor patient

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

_____

_____

Lawrence Park Orthodontics wants to make it easier to remind our patients of their appointments. In order to do that we need your assistance:

How do you prefer your confirmation call?
( ) text to cell phone: _____
Telephone company carrier _____

Patient Name: _____
Parental Authorization to receive texts:

Parent Signature_____

Date: _____