NATHAN RUBIN, D.D.S.
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Practice Limited to Orthodontics
(718) 868-1497

Name ____Date of Birth__________________ Today's Date _______________

GENERAL INFORMATION

Address ____ Telephone Daytime ( ) _________________
____ Zip _____________ Evenings ( ) ________________
Father's Name____ Mother's Name ____________________________________
Person Financially Responsible ____ Relationship ____________________
Business Address ____Occupation___________________________________
____ 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?

NO	YES		If yes, explain:
		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	YES 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 ______________________________________