READING ORTHODONTIC GROUP

Thank you for your interest in the Reading Orthodontic Group. Please fill out the information below and we will contact you to schedule an appointment time. We look forward to seeing you soon.

Our goal is to make every child's visit pleasant and educational. We pride ourselves in teaching excellent oral healthcare so your child's smile will last a lifetime.

1 ROG — Tell us about your child

Name: ______________________________
Address: ______________________________
____
Date of Birth: ______________ Age: ________
Home Phone #: ______________ Sex: M or F
Email: ______________________________
School: ______________________ Grade: ____
Hobbies/ Sports: ________________________
Family members treated in our office:
(name and relationship)
____
____
____
Reason for consultation: ___________________
Patient's dentist: ________________________
Whom may we thank for referring you?

2 ROG — Responsible Party Information

Name: ______________________________
Address: ______________________________
____
____
SS#: ______________ Employer: ______________
Work phone #: (____)______________
e-mail: ______________________________
Does patient have orthodontic insurance? Y or N

3 ROG — Father's Information

Name: ______________________________
Marital status:

separated ○ single ○ widowed ○ divorced ○ married

Address: ______________________________
____
SS#: ______________ Employer: ______________
Home phone #: (____)______________
Work phone #: (____)______________
Email: ______________________________
Orthodontic Insurance Co. ________________
Do you participate in a flex plan **Y** or **N**

4 ROG — Mother's Information

Name: ______________________________
Marital Status:

separated ○ single ○ widowed ○ divorced ○ married

Address: ______________________________
____
SS#: ______________ Employer: ______________
Home phone #: (____)______________
Work phone #: (____)______________
Email: ______________________________
Orthodontic Insurance Co. ________________
Do you participate in a flex plan **Y** or **N**

We ask for a 48 hour cancellation notice if you are unable to keep this appointment. Since this is a complimentary appointment, valued at $450, we will be unable to reschedule if you miss this appointment.

****Please mail, e-mail or fax this form to us ASAP. Thank you.****

Robert E. Doleva, D.M.D. — **Natalie M. Parisi, D.D.S.**

Phone: 610.374.4097 — **1268 Penn Avenue, Wyomissing, PA 19610** — **Fax: 610.372.8119**

www.fantasticsmiles.com

e-mail: braces@fantasticsmiles.com

Medical History

Circle Yes or No for which the patient has a history:

ADHD	Y N	Autoimmun	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sleep Apnea	Y N
AIDS	Y N	Bone Disorders	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Painful chewing	Y N	Speech problems	Y N
Allergies	Y N	Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	Thumb Sucking	Y N
Anemia	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	TMJ problems	Y N
Arthritis	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tooth Grinding	Y N
Asperger	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Tuberculosis	Y N
Aspirin	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Venereal Disease	Y N
Asthma	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N		
Autism	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N		

Any disease, problems, or allergies not mentioned above? ____________________

Current Medications? ____________________

Do you now or have you ever taken bisphosphonates, including, Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid or Zometa? ________ If yes, which drug ____________

Have wisdom teeth been extracted? ____________ Any face, mouth or teeth injuries? ____________

Does the patient normally breathe through the mouth while awake or asleep? ____________ Do gums bleed when brushed or flossed? ____________

Has an orthodontist been consulted previously? ____________ Have you had previous orthodontic treatment? ____________

Are there any missing or extra teeth? ____________ Have the tonsils and adenoids been removed? ____________

Any questions? ____________________

Signature: ____________________ Relationship To Patient: ____________ Date: ____________

I hereby acknowledge that I have read and understand the Reading Orthodontic Group Patient Privacy Notice (HIPAA). Copy available on request.

Signature: ____________________ Relationship To Patient: ____________ Date: ____________

READING
ORTHODONTIC GROUP

Smiles In Motion

We'll pick your child up from school!

CURRENTLY SERVING ALL SCHOOLS IN BERKS COUNTY and COCALICO SCHOOL DISTRICT!

Ask us for information on your school *TODAY!*

WE'RE ON A ROLL!

****Please mail, e-mail or fax this form to us ASAP. Thank you.****