

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.

Name: _____
 Address _____ Date of Birth: _____ Age: _____
 Home Phone #: _____ Work Phone #: _____ Sex: M or F
 SS#: _____ e-mail: _____
 Employer: _____ Position: _____ Orthodontic insurance: Y or N
 Orthodontic Insurance Co. _____ Do you participate in a flex plan Y or N
 Family members treated in our office (name and relationship): _____
 Reason for consultation: _____
 Patient's dentist: _____
 Whom may we thank for referring you? _____

Medical History

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

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

Signature: _____ Relationship To Patient: _____ Date: _____

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.

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If you have any questions regarding this form, please feel free to call our office