ROG ORTHODONTICS

WYOMISSING | DOUGLASSVILLE | POTTSTOWN

1 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?

Thank you for your interest in ROG Orthodontics 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.

2 Responsible Party Information

Name: _____

Address: _____

_____

_____

SS#:_____ DOB:_____

Employer: _____

Work phone #: (____)_____

e-mail: _____

Does patient have orthodontic insurance? Y or N

3 Father's Information

Name: _____

Marital status:

○ single ○ divorced ○ separated ○ widowed ○ married

Address: _____

_____

SS#:_____ DOB:_____

Employer: _____

Home phone #: (____)_____

Cell phone #: (_____)_____

Work phone #: (____)_____

Email: _____

Orthodontic Insurance Co. _____

Do you participate in a flex plan **Y** or **N**

4 Mother's Information

Name: _____

Marital Status:

○ single ○ divorced ○ separated ○ widowed ○ married

Address: _____

_____

SS#:_____ DOB:_____

Employer: _____

Home phone #: (____)_____

Cell 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.****

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Medical History

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

ADHD	Y N	Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sleep Apnea	Y N
AIDS	Y N	Bone Disorders	Y N	Down 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 ROG Orthodontics Patient Privacy Notice (HIPAA). Copy available on request.

Signature: _____ Relationship To Patient: _____ Date: _____

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