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.

Name: ____

Address: ____

____

Date of Birth: ________________ Age:______________ Gender:__________ Pronouns:______________

Home Phone #: ______________________ Cell Phone: ______________________

E-mail: ______________________________ Preferred Contact Method:______________

Emergency Contact: ____

Name Phone # Relationship

Employer: ________________ Position: ______________ Dental insurance: **Y** or **N**

Dental Insurance Co. ______________________ Member ID # or SSN:______________________

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

Family members treated in our office (name and relation): ______________________

____

Reason for consultation: ____

Patient's dentist: ____

Whom may we thank for referring you?____

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 bring this form with you to your appointment. ****

MEDICAL HISTORY

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

Allergies	Y N	Chest pains	Y N	Fainting, Dizziness	Y N	Kidney Problems	Y N	Pregnant	Y N	Thumb Sucking	Y N
Anemia	Y N	Chronic Neck Pain	Y N	Glaucoma	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Tooth Grinding	Y N
Arthritis	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Mouth Breathing	Y N	Rheumatic Fever	Y N	Tuberculosis	Y N
Asthma	Y N	Diabetes	Y N	Heart Condition	Y N	Muscular Disorders	Y N	Scoliosis	Y N	Venereal Disease	Y N
Autoimmune	Y N	Down Syndrome	Y N	Hepatitis	Y N	Nervous Disorders	Y N	Seizures	Y N		
Bone Disorders	Y N	Drug Allergies	Y N	High Blood Pressure	Y N	Organ Transplant	Y N	Sleep apnea	Y N		
Bulimia	Y N	Endocrine Problems	Y N	HIV/AIDS	Y N	Painful Chewing	Y N	Snoring	Y N		
Cancer	Y N	Emotional Disorders	Y N	Immune problems	Y N	Periodontal Problems	Y N	Smoking	Y N		
Cerebral Palsy	Y N	Epilepsy	Y N	Jaw Problems	Y N	Pneumonia	Y N	Speech problems	Y N		

Do you have a nickel or metal allergy/sensitivity? ______________ Do you have a latex allergy? ______________

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? ______________________

Do you normally breathe through the mouth while awake or asleep? __________ Do gums bleed when brushed or flossed? ______________

Have you previously consulted another orthodontist? __________ Have you had previous orthodontic treatment? ______________

Do you have any missing or extra teeth? ______________ Have your tonsils and adenoids been removed?______________

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

1268 Penn Avenue, Wyomissing, PA 19610
1204 Ben Franklin Highway West, Douglassville, PA 19518
1830 East High Street, Pottstown, PA 19464

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