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.

1 Tell Us About Your Child

Name: _____
Address: _____
_____
_____
Date of Birth:_____ Age:_____
Home Phone #:_____ Gender:_____
Pronouns:_____
School: _____
Hobbies/ Sports: _____
Family members treated in our office:
(name and relation)
_____
_____
_____
Reason for consultation: _____
_____
Patient's dentist: _____
Whom may we thank for referring you?_____
_____

2 Responsible Party Information

Name:_____
Address: _____
_____
Phone #: _____
SS#: _____ DOB:_____
Employer: _____
E-mail: _____

Does the **patient** have dental insurance? Y or N
Dental Insurance Company:_____
Member ID #:_____

3 Father's Information

Name: _____
Marital status:
○ Single ○ Divorced ○ Separated
○ Widowed ○ Married
Address: _____
_____
SS#: _____ DOB: _____
Employer: _____ Work phone#: _____
Home phone#: _____ Cell phone#: _____
Email: _____
Preferred Contact Method:_____
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: _____ Work phone#: _____
Home phone#: _____ Cell phone#: _____
Email: _____
Preferred Contact Method:_____
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 bring this form with you to your appointment. ****

1268 Penn Avenue, Wyomissing, PA 19610
1204 Ben Franklin Highway West, Douglassville, PA 19518
1830 East High Street, Pottstown, PA 19464
Phone: 610-374-4097 | Fax: 610-372-8119 | fantasticsmiles.com

MEDICAL HISTORY

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

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

Females: Have you started menstruating? _____ At what age? _____

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? _____

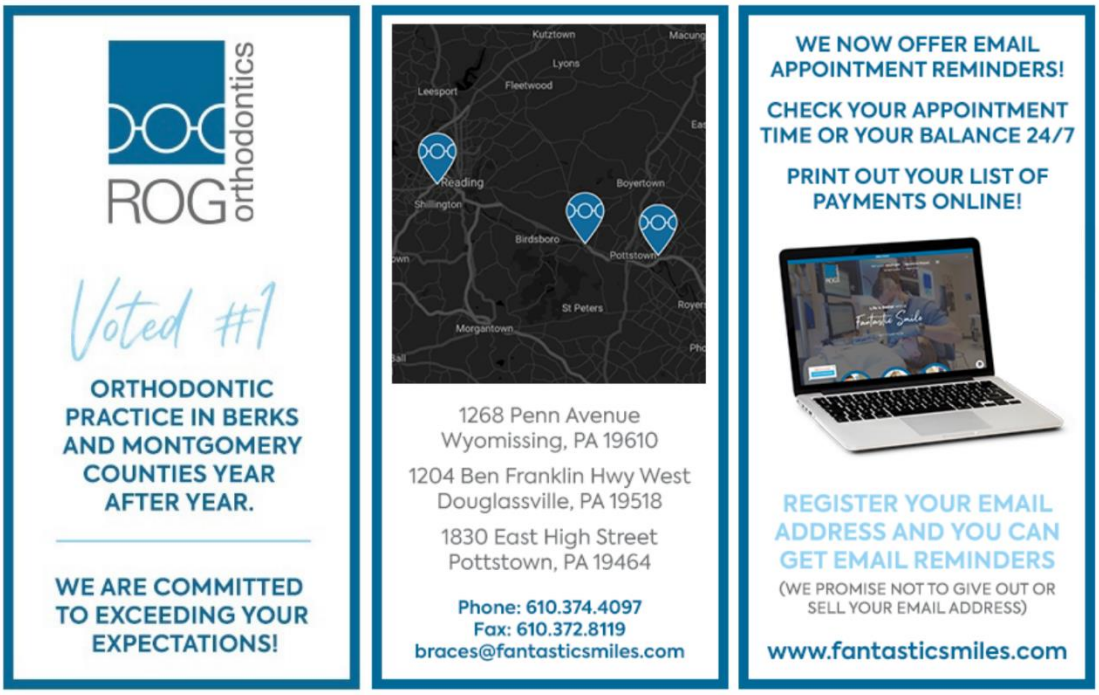
Are there any missing or extra teeth? _____ Have the tonsils and adenoids been removed?_____

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: _____



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