REED ORTHODONTICS

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DATE OF EXAM:

Patient's Information

NAME (LAST, FIRST, MI)	☐ MALE ☐ FEMALE	BIRTHDATE	SOCIAL SECURITY NUMBER — —
ADDRESS			HOME PHONE
CITY	STATE	ZIP	CELL PHONE
EMPLOYER	HOW LONG	POSITION	WORK PHONE

Spouse's Information

NAME (LAST, FIRST, MI)		BIRTHDATE	SOCIAL SECURITY NUMBER — —
ADDRESS			HOME PHONE
CITY	STATE	ZIP CODE	CELL PHONE
EMPLOYER	HOW LONG	POSITION	WORK PHONE

Dental History

GENERAL DENTIST	DATE OF LAST EXAM

	YES	NO	COMMENTS:
Do you maintain 6 month dental check-ups?	☐	☐	
Do your gums bleed while brushing?	☐	☐	
Do you clench or grind your teeth?	☐	☐	
Has your dentist suggested an orthodontic consultation?	☐	☐	
Have you ever had an orthodontic consultation?	☐	☐	
Have you ever had any orthodontic treatment?	☐	☐	

HOW DID YOU HEAR OF OUR OFFICE?

☐ DENTIST ☐ INSURANCE COMPANY ☐ NEWSPAPER ☐ PHONE BOOK
☐ TV/RADIO ☐ FRIEND_____ ☐ WEBSITE ☐ OTHER _____

NAMES OF ANYONE IN YOUR FAMILY WE HAVE SEEN

Insurance Information

DO YOU HAVE ORTHODONTIC INSURANCE? ☐ YES ☐ NO	NAME OF INSURANCE COMPANY	PHONE NUMBER
INSURED'S NAME	☐ SELF ☐ SPOUSE ☐ _____	SOCIAL SECURITY NUMBER — —

Financial Information

IF ORTHODONTIC TREATMENT IS NEEDED, WE CAN OFFER A CHOICE OF PAYMENT OPTIONS FOR FEES OVER $300 (PLEASE CHOOSE ONE)

☐ PAYMENT IN FULL (MASTERCARD, VISA, CASH, MONEY ORDER, CHECK) ☐ MONTHLY PAYMENTS - INTEREST FREE INSTALLMENT PAYMENT PLAN

NAME (LAST, FIRST, MI)	☐ SELF ☐ SPOUSE ☐	SOCIAL SECURITY NUMBER

ADDRESS	HOME PHONE

CITY	STATE	ZIP CODE	CELL PHONE

EMPLOYER	HOW LONG	POSITION	WORK PHONE

Medical Information

MEDICAL DOCTOR	DATE OF LAST EXAM

ARE YOU UNDER A DOCTOR'S CARE NOW? ☐ YES ☐ NO	FOR WHAT REASON?

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? ☐ YES ☐ NO	FOR WHAT REASON?

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO	IF YES, PLEASE LIST

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO	IF YES, PLEASE LIST

Are you taking any medication for osteoporosis? ☐ YES ☐ NO

HAVE YOU EVER HAD:

	YES	NO
Asthma	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Hepatitis or HIV/AIDS	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Abnormal Heart Condition	☐	☐
Abnormal Bleeding from a cut	☐	☐
Abnormal Blood Pressure	☐	☐

ARE YOU ALLERGIC TO:

	YES	NO
Penicillin	☐	☐
Local Anesthetic	☐	☐
Latex (Rubber Gloves)	☐	☐
Metals (ie. earrings)	☐	☐

This acknowledges receipt of the Notice of Privacy Practices.

By signing this form, I confirm that the above information is true and accurate.

COMMENTS: