K. Noel Reed Jr., D.D.S., M.S.

Specialist in Dentofacial Orthopedics & Orthodontics

Patient Information

Date:

Last Name: First: Goes By:

Address: City: Zip:

Primary Telephone #: Please circle: Home or Cell Primary email:

DOB: Sex: M or F School Attending:

General Dentist: Have you had a previous Orthodontic consultation or work? Y ES NO

Whom may we thank for referring you to the office?

Do you have dental / orthodontic insurance? YES NO If yes, Company Name:

Parent or Guardian

Last Name: First : Relation to Patient:

Address: City: Zip:

Home Phone# Cell# Email:

DOB: SS# Employer:

Spouse Name: Relation to Patient:

Address: City: Zip:

Home Phone# Cell# Work#

DOB: SS# Employer:

Email Address:

Emergency Information

Name of nearest relative not living with you: Phone #

Complete Address:

Appointment Policy

- *I am aware that some appointments will infringe on school and/or work time. Also, most of our patients are of school age, therefore, they cannot all be seen after school. All long appointments such as: placing braces, removing braces, records, emergencies, and broken appointment make-ups, are made between the hours of 9a.m. & 2:30p.m. Regular adjustments are made after school as space is available.*

Signed: *Date:*

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Medical History: *please answer yes or no to the following questions*						***Dental History:***	
YES	NO	**Adenoids removed**	YES	NO	**Anemia**	YES	NO	**Head/Face injuries**
YES	NO	**AIDS/HIV pos.**	YES	NO	**Hepatitis**	YES	NO	**Dental injuries**
YES	NO	**Mouth breathing**	YES	NO	**Kidney problems**	YES	NO	**Thumb sucking**
YES	NO	**Speech/hearing prob.**	YES	NO	**Asthma**	YES	NO	**Finger sucking**
YES	NO	**Allergies**	YES	NO	**Rheumatic fever**	YES	NO	**Cheek/lip/nail biting**
YES	NO	**High/Low BP**	YES	NO	**Heart disease**	YES	NO	**Click/pop of jaw**
YES	NO	**Drug sensitivity**	YES	NO	**Heart murmur**	YES	NO	**Jaw pain**
YES	NO	**Neurological Prob.**	YES	NO	**Stroke**	YES	NO	**Pain around ear**
YES	NO	**Radiation treatment**	YES	NO	**Tuberculosis**	YES	NO	**Frequent headaches**
YES	NO	**Venereal disease**	YES	NO	**Diabetes**	YES	NO	**Bleeding gums**
YES	NO	**Pregnancy**	YES	NO	**Endocrine problems**	YES	NO	**Sensitive teeth**
YES	NO	**Ulcer or Colitis**	YES	NO	**Bone disorders**	YES	NO	**Frequent cold sores**
YES	NO	**Cancer/Leukemia**	YES	NO	**Epilepsy**	YES	NO	**Mouth Ulcers**
YES	NO	**Tonsillitis/Adenitis**	YES	NO	**Psychiatric care**	YES	NO	**Peridontal treatment**
YES	NO	**Tonsils removed**	YES	NO	**Cleft lip/ palate**	YES	NO	**Cigarette smoking**
YES	NO	**Arthritis**				YES	NO	**Pipe smoking**

Please describe any current medical treatment including any current medications taken and current physician:

YES	NO	**Has the patient ever been treated in the emergency room? If yes, Why?**
YES	NO	**Has the patient had unfavorable reactions to medicine? If yes, please describe:**
YES	NO	**Does the patient currently take any medications? If yes, what type?**
YES	NO	**Is the patient concerned with his or her teeth?**
YES	NO	**Does the patient play a musical instrument that involves using the mouth?**
YES	NO	**Has any family member had orthodontic treatment?**

Signed: _____ *Date:* _____