

Patient's Name: First _____ Last _____ Middle Initial _____

Preferred Name _____ Date of Birth _____ Male Female

How did you hear about our office? _____

Patient Medical History

	Yes	NO		Yes	NO
Heart Murmur/Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Occupational Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis/Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding When Cut.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion, Date _____	<input type="checkbox"/>	<input type="checkbox"/>	Metallic Implant.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Tumor.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Is the patient pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Puberty/ Growth Spurt.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Bone Density Medication (ex: Fosomax).....	<input type="checkbox"/>	<input type="checkbox"/>
Latex Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Issues.....	<input type="checkbox"/>	<input type="checkbox"/>

Is there any Drug/ Food/ Dye/ Metal/ Other Aller* y? If yes, to what medication/foods

Is there any other health information that should be known? _____

Is the patient taking any medications/ vitamin supplements/ recreational drugs? YES NO

If yes, please list the medications & reasons:

Has the patient recently been under the care of a physician or had a serious illness or operation in the last 5 years?

YES NO If yes, please explain

Name & phone number of the patient's physician: _____

Has the patient experienced any unfavorable reaction from any previous dental or medical care? YES NO

If yes, please explain

Emergency Contact & Consent to Release Information

I give my consent to allow someone other than myself to accompany my child for appointments, to release healthcare information at the appointment or to secure payment for dental services. I understand I can revoke this consent at any time by providing written notice.

Persons who have consent in my absence are 1)

2)

Name & Phone of nearest relative not living with you _____

I give my consent for Dr. Mark Feinberg and Mark Feinberg Orthodontics to perform a complete dental and oral examination on the patient named previously. X-rays that are necessary may be taken. Any additional dental treatment received will be fully explained prior to its completion at each visit.

Insurance portions are an estimate based on information released by my insurance company. IT DOES NOT GUARANTEE PAYMENT. I am aware that the insurance coverage is a contract between me and my carrier. As a courtesy, claims may be filed on my behalf. Should any dispute occur or if I fail to provide accurate information, I understand I am financially responsible to the doctors for all dental treatment.

I agree to inform the doctor of any changes in medical or financial information. I acknowledge that I have read the Notice of Privacy Act and that a copy will be made available to me upon request.

X _____

Sign

Date

Relationship to Patient _____

Previous Dental History

Last Dental Visit & Reason: _____

Dentist's Name & Phone Number: _____

Does the patient have a specific dental problem that needs attention? YES NO If yes, please explain

Has any member of your family received dental treatment in this office before? Names: _____

Orthodontic Section

Patient's Current Dentist
Name & Phone Number _____

Has an orthodontist been previously consulted? YES NO Dr's Name: _____

Chief Concerns: Crowding Overbite Shifting/ Relapse of teeth
 Spaces Underbite Dental Referral
 Missing teeth TMJ Pain Oral Habits/ Tongue Thrust

Other: _____

Responsible Party Information

Father/Mother _____

Last First Middle Initial Marital Status Driver's License #
Address _____
Street City State Zip

How long at this address _____ Primary Phone _____ Secondary Phone _____

Email Address _____ Social Security # _____ Date of Birth _____

Employer _____ Occupation _____ Years Employed _____

Work Phone & Ext _____ Preferred Method of Contact: Email _____ or Phone _____ Please check one

Father/Mother _____

Last First Middle Initial Marital Status Driver's License #
Address (if not the same) _____
Street City State Zip

How long at this address _____ Home Phone _____ Cell Phone _____

Email Address _____ Social Security # _____ Date of Birth _____

Employer _____ Occupation _____ Years Employed _____

Work Phone & Ext _____ Preferred Method of Contact: Email _____ or Phone _____ Please check one

Dental Insurance Information

Insured's Name _____ Insured's ID # _____ Birth Date _____

Primary Insurance Company _____ Group # _____ Effective Date _____

Insurance Co. Address _____

Insurance Co. Phone # _____ Insured's Employer _____

Do you have dual coverage? Yes No If Yes:

Insured's Name _____ Insured's ID # _____ Birth Date _____

Secondary Insurance Company _____ Group # _____ Effective Date _____

Insurance Co. Address _____

Insurance Co. Phone # _____ Insured's Employer _____