

ORTHODONTIC QUESTIONNAIRE AND ACQUAINTANCE FORM WALTER FELDMAN D.D.S.

Patient's Name _____ Date _____

Male _____ Female _____ Age _____ Birth Date _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Employed By _____ SS# _____

Employer's Address _____ City _____ Zip _____

SPOUSE'S INFORMATION

Name _____ Birth Date _____

Employed By _____ SS# _____

Employer's Address _____ City _____ Zip _____

INSURANCE INFORMATION

Primary Insurance _____ Cardholder's Name _____

Secondary Insurance _____ Cardholder's Name _____

OTHER

Referred By _____

Patient's Dentist _____ Phone _____

Address _____ City _____ Zip _____

MEDICAL HISTORY

For the following questions, please check whichever applies. Your answers are for our records only and will be considered confidential.

	YES	NO
Are you in good health?	_____	_____
Are you currently under the care of a physician?	_____	_____
Are you taking any prescription /non-prescription drugs?	_____	_____
Have you been hospitalized for any reason?	_____	_____

If yes, please explain _____

Have you any of the following diseases or medical problems?

- | | | |
|--|---|---|
| Y N | Y N | Y N |
| <input type="radio"/> <input type="radio"/> Heart Surgery/Pacemaker | <input type="radio"/> <input type="radio"/> Hepatitis | <input type="radio"/> <input type="radio"/> Severe/Frequent Headaches |
| <input type="radio"/> <input type="radio"/> Hemophilia/Abnormal Bleeding | <input type="radio"/> <input type="radio"/> Asthma | <input type="radio"/> <input type="radio"/> Artificial Bones/Joints/Valves |
| <input type="radio"/> <input type="radio"/> High/Low Blood Pressure | <input type="radio"/> <input type="radio"/> Diabetes | <input type="radio"/> <input type="radio"/> Pneumatic Fever |
| <input type="radio"/> <input type="radio"/> Congenital Heart Defect | <input type="radio"/> <input type="radio"/> Shingles | <input type="radio"/> <input type="radio"/> Epilepsy/Seizures/Fainting Spells |
| <input type="radio"/> <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> <input type="radio"/> Kidney Problems | <input type="radio"/> <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> <input type="radio"/> Allergies/Sinus Problems | <input type="radio"/> <input type="radio"/> HIV/AIDS | |
| <input type="radio"/> <input type="radio"/> Radiation Treatment | <input type="radio"/> <input type="radio"/> Anemia | |

Are you allergic to any medications? If so, please list.

Are you allergic to any latex, metal, or plastic? If so, please list.

	YES	NO
Do you have any jaw problems?	_____	_____
Do you have any pain, popping, clicking, or cracking during jaw movement? (If so, please explain symptom, location, and duration.	_____	_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be kept confidential and I will inform this office of any changes in my medical status.

SIGNATURE _____ Date _____

Update Signature _____ Date _____