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

Patient's Name_____ Date_____

Male _____ Female _____ Age_____ Birth Date_____

Address_____City_____Zip_____

Phone # _____ Alternate # _____

MOTHER'S INFORMATION

Name_____Phone_____

Address_____City_____Zip_____

Employed By_____Birth Date_____ SS#_____

Employer's Address_____City_____Zip_____

FATHER'S INFORMATION

Name_____Phone_____

Address_____City_____Zip_____

Employed By_____Birth Date_____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	
o	o	Heart Surgery/Pacemaker	o	o	Hepatitis	o	o	Severe/Frequent Headaches
o	o	Hemophilia/Abnormal Bleeding	o	o	Asthma	o	o	Artificial Bones/Joints/Valves
o	o	High/Low Blood Pressure	o	o	Diabetes	o	o	Pneumatic Fever
o	o	Congenital Heart Defect	o	o	Shingles	o	o	Epilepsy/Seizures/Fainting Spells
o	o	Mitral Valve Prolapse	o	o	Kidney Problems	o	o	Rheumatic Fever
o	o	Allergies/Sinus Problems	o	o	HIV/AIDS			
o	o	Radiation Treatment	o	o	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_____