Patient Information

Date ______________ E-mail ______________ Home Phone ______________
MM DD YYYY

Patient's Name ______________ Date of Birth ______________
Last First Middle

Preferred Name (Nick Name) ______________ Male ☐ Female ☐ SS# ______________

Residence ______________
Street Number Street Suite/Apt City State Zip

If patient is a minor, who is legal guardian ______________ Relationship to patient ______________

Whom may we thank for referring you to our office? ______________

Responsible Party Information

Name ______________ Marital Status ______________
Last First Middle

Residence ______________
Street Number Street Suite/Apt City State Zip

Mailing Address ______________
(If different than residence) Street Number Street Suite/Apt City State Zip

How long at this address ______ Home Phone ______________ Work Phone ______________ Cell Phone ______________
Years

Previous Address ______________
(If less than 3 years) Street Number Street Suite/Apt City State Zip

Employer ______________ Occupation ______________ Time at Current Employment ______________
Years

Employer Address ______________
Street Suite/Apt City State Zip

Date of Birth ______________ Social Security Number ______________ Relationship to Patient ______________

Responsible Party's E-mail ______________

Spouse's Name ______________ Relationship to Patient ______________
Last First Middle

Date of Birth ______________ Social Security Number ______________ Work Phone ______________

Employer ______________ Occupation ______________ Time at Current Employment ______________
Years

Responsible Party Information

Primary Insurance Company Name ______________ Policy/Group # ______________ Telephone ______________

Insurance Company Address ______________
Street Suite/Apt City State Zip

Primary Insurance Held By ______________ SS# ______________
(Whose name is on the insurance policy) Last First Middle if not given above

Secondary Insurance Company Name ______________ Policy/Group # ______________ Telephone ______________

Sec. Insurance Co. Address ______________
Street Suite/Apt City State Zip

Sec. Insurance Held By ______________ SS# ______________
(Whose name is on the insurance policy) Last First Middle if not given above

IN CASE OF EMERGENCY Please Contact ______________ Telephone ______________
(nearest relative not living with you) First Last

Complete Address ______________
Street Suite/Apt City State Zip

I understand that where appropriate, credit bureau reports may be obtained. ______________
Signature of Responsible Party

Medical History

Patient Name ______________________________

Family Physician ____________ Date of Last Visit __________ Are you in good health? Yes ☐ No ☐

Have you experienced any of the following: For all yes answers please provide specifics below:

Condition	Yes	No	Specifics
Sinus Problems	☐	☐	Specifics:
Ear/Nose/Throat Problems	☐	☐	Specifics:
Eye Problems	☐	☐	Specifics:
Muscle/Neural Problems	☐	☐	Specifics:
Bone Problems	☐	☐	Specifics:
Hormone Problems	☐	☐	Specifics:
Blood Problems	☐	☐	Specifics:
Kidney/Liver Problems	☐	☐	Specifics:
Urinary/Bladder Problems	☐	☐	Specifics:
Stomach/Intestinal Problems	☐	☐	Specifics:
Heart/Lung Problems	☐	☐	Specifics:
Head/Neck Problems	☐	☐	Specifics:
Back/Shoulder Problems	☐	☐	Specifics:

Allergies ☐ Metal ☐ Latex ☐ Drugs (Please List) __________

☐ Foods (Please List) __________ ☐ Other (Please List) __________

Please check any that apply:	Heart Problems		Breathing Problems	Chronic Disease	
Childhood/One Time Diseases	☐ Murmur	☐ High Blood Pressure	☐ Asthma	☐ Tuberculosis	☐ Cancer
☐ Mumps	☐ Chest Pain	☐ Heart Valve Problem	☐ Hay Fever	☐ Hepatitis A	☐ Diabetes
☐ Measles	☐ Angina	☐ Heart Failure/Attack	☐ Wheezing	☐ Hepatitis B	☐ HIV/AIDS
☐ Chicken Pox	☐ Palpations	☐ Coronary Disease	☐ Chronic Cough	☐ Hepatitis C	☐

Any other health problems or surgeries: ______________________________

List any medications now being taken: ______________________________

Dental History

Family Dentist ____________ Date of Last Visit __________ Yearly Checkups? One ☐ Two ☐ Never ☐

	Yes	No			
Jaw or Face Injury/Trauma	☐	☐	☐ Broken Jaw	☐ Other (Explain)	
Tooth Injury/Trauma	☐	☐	☐ Broken	☐ Chipped	☐ Lost
Mouth Habits	☐	☐	☐ Thumb/Finger Sucking	☐ Lip/Tongue Habits Until Age	
Bleeding Gums	☐	☐	☐ After Brushing	☐ After Flossing	☐ All Times
Ever Had Speech Therapy?	☐	☐	Advised By:	For:	
Jaw Joint Pain	☐	☐	Explain:		
Jaw Joint Popping/Clicking	☐	☐	☐ Both Sides	☐ Right Side	☐ Left Side

Fun Stuff about you: ______________________________

How do you feel about braces ______________________________

What are you most excited about changing in your smile? ______________________________

Sports or hobby interests ______________________________

What name do you prefer (nickname) ______________ What pets do you have? ______________

Any questions for Dr. Feller? ______________________________

I understand and certify that the information I have given on this form is correct and that I am obligated to inform Dr. Feller immediately if any of this information changes in the future.

Signature of Parent or Parent/Guardian if patient if a minor ______________________________