Patient Information

Date _____

Patient's Name _____
First Middle Last

Residence _____
Address City State Zip

Phone _____ Date of Birth _____ ☐ Male ☐ Female

E-mail address of Patient _____

If patient is a minor, who is legal guardian? _____

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

Custodial Parent/Responsible Party

Responsible Party Information

Name _____ Marital Status _____
First Middle Last

Residence _____
Address City State Zip

MailingAddress _____
(If different than residence) Address City State Zip

Previous Address _____
(If less than 3 years) Address City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Employment _____ Yrs _____ Mos E-mail Address(s) _____

Date of Birth _____ Relationship to **Patient** _____

Spouse's Name _____
First Middle Last

Date of Birth _____ Cell Phone _____

Employer _____ Occupation _____ Employment _____ Yrs _____ Mos

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Insurance

PRIMARY Insurance Held By _____ Date of Birth _____
First Middle Last

Member ID# _____ Group # _____ Insurance Phone # _____

Primary Insurance Company _____

Insurance Address _____
Address City State Zip

SECONDARY Insurance Held By _____ Date of Birth _____
First Middle Last

Member ID# _____ Group # _____ Insurance Phone # _____

Secondary Insurance Company _____

Secondary Insurance Address _____
Address City State Zip

IN CASE OF EMERGENCY Please contact _____ Telephone _____
(nearest relative not living with you) First Middle Last

Complete Address _____
Address City State Zip

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

Please TURN OVER to complete second page...

Medical History

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

Allergies Metal ☐ Latex ☐ Drugs (Please List) _____

Foods (Please List) _____ Other (Please List) _____

Have you experienced any of the following:			For all yes answers please provide specifics below:
ADD/ADHD	Yes ☐	No ☐	Specifics: _____
Arthritis	Yes ☐	No ☐	Specifics: _____
Blood Problems	Yes ☐	No ☐	Specifics: _____
Bone Problems	Yes ☐	No ☐	Specifics: _____
Ear/Nose/Throat Problems	Yes ☐	No ☐	Specifics: _____
Herpes	Yes ☐	No ☐	Specifics: _____
Hormone Problems	Yes ☐	No ☐	Specifics: _____
Mental Disorder	Yes ☐	No ☐	Specifics: _____
Muscle/Neural Problems	Yes ☐	No ☐	Specifics: _____
Sinus Problems	Yes ☐	No ☐	Specifics: _____
Tonsils/Adenoids removed	Yes ☐	No ☐	Specifics: _____

Please check any that apply:

Heart Problems
- ☐ Murmur
- ☐ Palpatations
- ☐ Rheumatic Fever
- ☐ Heart Failure/Attack
- ☐ Coronary Disease

Breathing Problems
- ☐ Sleep Apnea
- ☐ Asthma

Chronic Diseases
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Hepatitis A
- ☐ Diabetes
- ☐ Hepatitis B
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ Other

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 ☐

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

Hobbies/Interests _____

Any questions for Dr. Feller / Dr. Johnson? _____

Do you prefer Invisalign or Damon Braces? _____

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

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 Patient or Parent/Guardian if patient is a minor _____