Feigenbaum Dental

Creating Beautiful Smiles with a Gentle Touch

PLEASE COMPLETE BOTH SIDES

Name_____ (First) (Middle) (Last) | ❑ M ❑ F Sex | Nickname_____

Address_____ (Street) (City) (Zip Code) Home Phone (___) ___-____

Date of Birth_____ Height_____ Weight_____

Father _____ Work Phone (___) ___-____

Employed by_____ Address_____

Mother_____ Work Phone (___) ___-____

Employed by_____ Address_____

Referred to our office by_____

Please indicate which of the following your child has had or has at present. Please check "yes" or "no" to each item.

Heart Trouble	❑ yes	❑ no	Measels	❑ yes	❑ no
Rheumatic fever	❑ yes	❑ no	Scarlet fever	❑ yes	❑ no
Diabetes	❑ yes	❑ no	Chicken pox	❑ yes	❑ no
Asthma	❑ yes	❑ no	Mumps	❑ yes	❑ no
Anemia	❑ yes	❑ no	Whopping cough	❑ yes	❑ no
Epilepsy	❑ yes	❑ no	Tonsils removed	❑ yes	❑ no
Tuberculosis	❑ yes	❑ no	Adenoids removed	❑ yes	❑ no
Kidney problems	❑ yes	❑ no	Any illness resulting in high fever before age 2?	❑ yes	❑ no
Liver problems	❑ yes	❑ no	If yes, what?_____		
Any other medical conditions	❑ yes	❑ no	Others	❑ yes	❑ no
If yes, what?_____			If yes, what?_____		
			Any recent surgery or hospitalization?	❑ yes	❑ no
			If yes, explain?_____		
Is your child:			Taking any medications?	❑ yes	❑ no
In good health?	❑ yes	❑ no	If yes, what?_____		
Subject to profuse bleeding?	❑ yes	❑ no			
Subject to nervous disorders?	❑ yes	❑ no			
Subject to fainting or diziness?	❑ yes	❑ no	**Does your child have any of these habits:**		
Sensitive or allergic to any drug?	❑ yes	❑ no	Mouth breathing?	❑ yes	❑ no
If yes, what?_____			Thumb sucking?	❑ yes	❑ no
Any other allergies?	❑ yes	❑ no	Pacifier?	❑ yes	❑ no
If yes, what?_____					

Name of Physician_____ Phone (___) ___-____

Date of last Medical Examination_____ Give age child walked_____ Talked_____

When was the last visit to dentist_____ Service received_____

Has your child experienced any unfavorable reaction to past dental care: ❑ yes ❑ no Medical care: ❑ yes ❑ no

How often are teeth brushed_____ By whom_____

Name of Previous Dentist_____ Phone (___) ___-____

Hobbies & Interests_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder_____	Policy Holder_____
Date of Birth_____	Date of Birth_____
Relationship to Patient_____	Relationship to Patient_____
Employer_____	Employer_____
Group #_____	Group #_____
SS#/ID#_____	SS#/ID#_____
Name of Insurance Co._____	Name of Insurance Co._____
Address_____	Address_____
_____	_____
Phone #_(_____)_____-_____	Phone #_(_____)_____-_____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge.

Because_____ is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental service can be started and accomplished by Feigenbaum Dental Associates, Ltd. Furthermore, I will be responsible for any fees incurred for this child for dental treatment. Authorization is hereby granted:

_____ _____

Signature (Parent or Guardian) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (parent/guardian)_____, have been made aware of this office's Notice of Privacy Practices.

_____ _____

Signature (Parent or Guardian) Date