FEIGENBAUM DENTAL

Creating Beautiful Smiles With A Gentle Touch

Name ______________________________ ❑ M ❑ F (Sex) | ❑ S ❑ M ❑ W ❑ D (Marital Status)
(First) (Middle) (Last)

Address ______________________________
(Street) (City) (Zip Code)

Home Phone ( ) - Cell Phone ( ) - Email

Employed by ______________________ Occupation ______________________

Work Phone ( ) - ext. Date of Birth ______________________

Patient SS# ______________________ Spouse Name ______________________

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.
Claims Address	Claims Address
Phone # ( ) -	Phone # ( ) -

Hobbies and Interests ______________________

Emergency Contact ______________ Relationship ________ 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.

______________________ (Signature of Dentist)

______________________ (Signature of Patient)

Patient Name

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? . . . . ❑ yes ❑ no
   If yes, for what ____________
   Physician's Name ____________ Phone ____________
   Address ____________ City ____________ State ________ Zip ________
2. Have you taken any medication or drugs during the past two years? . . . . ❑ yes ❑ no
3. Are you taking any medication, drugs or pills now? . . . . ❑ yes ❑ no
   If yes, please list name, dosage & what medication is for ____________
4. Are you taking or have you ever taken biophosphonates (Actonel, Fosamax, Boniva)? . . . . ❑ yes ❑ no
5. Are you aware of having an allergic (or adverse) reaction to any medications or substance? . . . . . ❑ yes ❑ no
   If yes, please list: ____________
6. Have you been a patient in the hospital during the past five years? . . . . ❑ yes ❑ no
   If yes, please explain: ____________
7. Indicate which of the following you have had, or have at present. Please check "yes" or "no" to each item.

Condition			Condition			Condition		
A.I.D.S./HIV+	❑ yes	❑ no	COPD	❑ yes	❑ no	Latex Sensitivity	❑ yes	❑ no
Allergies or Hives	❑ yes	❑ no	Depression	❑ yes	❑ no	Liver Disease	❑ yes	❑ no
Alzheimers	❑ yes	❑ no	Diabetes	❑ yes	❑ no	Mitral Valve Prolapse	❑ yes	❑ no
Arthritis/Rheumatism	❑ yes	❑ no	Emphysema	❑ yes	❑ no	Multiple Sclerosis	❑ yes	❑ no
Artificial Heart Valve	❑ yes	❑ no	Epilepsy or Seizures	❑ yes	❑ no	Premedication	❑ yes	❑ no
Artificial Joints(hip, knee, etc.)	❑ yes	❑ no	Fainting or Dizzy Spells	❑ yes	❑ no	Psychiatric/Psychological Care	❑ yes	❑ no
Aspirin Regimen	❑ yes	❑ no	Fever Blisters	❑ yes	❑ no	Radiation Therapy	❑ yes	❑ no
Asthma	❑ yes	❑ no	Frequent Headaches	❑ yes	❑ no	Rheumatic Fever	❑ yes	❑ no
Blood Disorder ITP	❑ yes	❑ no	Glaucoma	❑ yes	❑ no	Sexually Transmitted Disease	❑ yes	❑ no
Blood Transfusion	❑ yes	❑ no	Heart Attack, Disease, Surgery	❑ yes	❑ no	Sickle Cell Disease	❑ yes	❑ no
Cancer	❑ yes	❑ no	Heart Murmur	❑ yes	❑ no	Sinus Trouble	❑ yes	❑ no
Chemotherapy	❑ yes	❑ no	Heart Pacemaker	❑ yes	❑ no	Stroke	❑ yes	❑ no
Chest Pain	❑ yes	❑ no	Hemophilia	❑ yes	❑ no	Thyroid Problems	❑ yes	❑ no
Chronic Cough	❑ yes	❑ no	Hepatitis A	❑ yes	❑ no	Tuberculosis	❑ yes	❑ no
Cold Sores/Fever Blisters	❑ yes	❑ no	Hepatitis B	❑ yes	❑ no	Ulcers	❑ yes	❑ no
Congenital Heart Disease	❑ yes	❑ no	High Blood Pressure	❑ yes	❑ no	VSD	❑ yes	❑ no
Contact Lenses	❑ yes	❑ no	Kidney Trouble	❑ yes	❑ no			

8. Do you have or have you had a disease, condition, or problem not listed? . . . . ❑ yes ❑ no
   If yes, please list: ____________
9. **Women:** Are you: **Pregnant?** ❑ yes, months ____ ❑ no **Nursing?** ❑ yes ❑ no **Taking birth control pills**? ❑ yes ❑ no

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature ____________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____________, have been made aware of this office's Notice of Privacy Practices.
(print name)

____________ Signature ____________ Date

Patient Name

DENTAL HISTORY

Welcome**! So that we may provide you with the best possible care* ***PLEASE COMPLETE BOTH SIDES *of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? ______________________________

____

Date of Last Dental Visit: ___/___/___ **Last Dental Cleaning:** ___/___/___ **Last Full Mouth X-rays:** ___/___/___

What was done at your last dental visit? ______________________________

Previous Dentist's Name ______________________________ Telephone ______________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

Do you have any dental problems now? ❏ yes ❏ no

If yes, please describe: ______________________________

____

Are any of your teeth sensitive to:

Hot or cold? ❏ yes ❏ no

Sweets? ❏ yes ❏ no

Biting or chewing? ❏ yes ❏ no

Have you noticed any mouth odors or bad taste? ❏ yes ❏ no

Do you frequently get cold sores, blisters or any other oral lesions? ❏ yes ❏ no

Do your gums bleed or hurt? ❏ yes ❏ no

Have your parents experienced gum disease or tooth loss? ❏ yes ❏ no

Have you noticed any loose teeth or change in your bite? ❏ yes ❏ no

Does food tend to become caught in between your teeth? ❏ yes ❏ no

If yes, where? ______________

Do you:

Clench or grind your teeth while awake or asleep? ❏ yes ❏ no

Bite your lips, fingernails or cheeks regularly? ❏ yes ❏ no

Hold foreign objects with teeth? (pencils, pipe, pins, nails) ❏ yes ❏ no

Mouth breathing while awake or asleep? ❏ yes ❏ no

Have tired jaws, especially in the morning? ❏ yes ❏ no

Smoke/chew tobacco? ❏ yes ❏ no

Do you snore? ❏ yes ❏ no

Have you been diagnosed with sleep apnea? ❏ yes ❏ no

Have you ever had:

Orthodontic treatment? ❏ yes ❏ no

Oral surgery? ❏ yes ❏ no

Periodontal treatment? ❏ yes ❏ no

Your teeth ground or the bite adjusted? ❏ yes ❏ no

A bite plate or mouth guard? ❏ yes ❏ no

A serious injury to the mouth or head? ❏ yes ❏ no

If yes, please describe, including cause ______________

____

Have you experienced:

Clicking or popping of the jaw? ❏ yes ❏ no

Pain? (joint, ear, side of face) ❏ yes ❏ no

Difficulty in opening or closing mouth? ❏ yes ❏ no

Difficulty in chewing on either side of the mouth? ❏ yes ❏ no

Headaches, neckaches or shoulder aches? ❏ yes ❏ no

Sore muscles (neck, shoulders)? ❏ yes ❏ no

Are you satisfied with your teeth's appearance? ❏ yes ❏ no

Do you feel nervous about having dental treatment? ❏ yes ❏ no

If so, what is your biggest concern? ______________

____

Have you ever had an upsetting dental experience? ❏ yes ❏ no

If yes, please describe ______________

____

Here at Feigenbaum Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Grinding Night Guard	Implant Crowns	Veneers
Smile Makeover	Sports Mouth Guard	Crown and Bridge	Bonding
Snoring/Sleep Apnea Guard	Partials/Dentures	Sealants	Invisalign