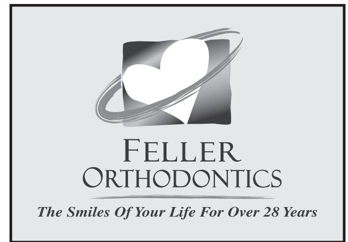
Patient Information



Date ______________________________

Patient's Name ______________________________
Last First Middle

Residence ______________________________
Street Number Street Suite/Apt City State ZIP

Phone ______________________ Date of Birth ______________________ ☐ Male ☐ Female

If patient is a minor, who is legal guardian ______________________ E-mail Address of Patient ______________________

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

Custodial Parent/Responsible Party

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 ______________________ Employment _______ Yrs. _______ Mos.

E-mail Address(es) ______________________________

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

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

Date of Birth __________ Social Security Number __________ Work Phone __________ Cell Phone __________

Employer ______________________ Occupation ______________________ Employment _______ Yrs. _______ Mos.

Insurance

Primary Insurance Held By ______________________________ Date of Birth ______________________
Last First Middle

Member ID # ______________________ Group # ______________________ Insurance Phone # ______________________

Primary Insurance Company ______________________________

Address ______________________________
Street Number Street Suite/Apt City State ZIP

Secondary Insurance Held By ______________________________ Date of Birth ______________________
Last First Middle

Member ID # ______________________ Group # ______________________ Insurance Phone # ______________________

Secondary Insurance Company ______________________________

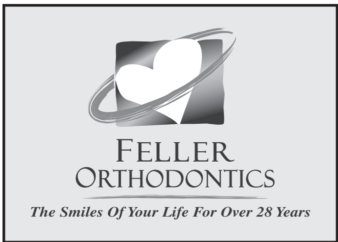
Address ______________________________
Street Number Street Suite/Apt City State ZIP

IN CASE OF EMERGENCY Please contact ______________________________ Telephone ______________________
(Nearest relative not living with you) Last First Middle

Complete Address ______________________________
Street Number Street Suite/Apt City State ZIP

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

(over)



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:

Condition	Yes	No	Specifics
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		Breathing Problems	Chronic Diseases	
❑ Murmur	❑ Palpitations	❑ Sleep Apnea	❑ Tuberculosis	❑ Cancer
❑ Rheumatic Fever		❑ Asthma	❑ Hepatitis A	❑ Diabetes
❑ Heart Failure/Attack			❑ Hepatitis B	❑ HIV/AIDS
❑ Coronary Disease			❑ 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 ____

Hobbies/Interests

Sports or Hobby Interests ____________________

What pets do you have? ____________________

Names / Ages of Siblings ____________________

Any questions for Dr. Feller? ____________________

How do you feel about traditional braces or Invisalign? ____________________

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 ____________________