



Edward Feins D.M.D.

Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs please fill out this form completely in ink. If you have any questions or need assistance please ask us and we will be happy to help

Patient Information (Confidential)

Patient Number _____

Date _____

Name _____

SS#/SIN _____ Birthdate _____

Address _____

City _____ State/Prov _____ Zip/P.C. _____

Home Phone _____ Cell Phone _____

Email _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

If Student Name of School/College _____ Full Time Part Time

City _____ State/Prov _____ Zip/P.C. _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____

City _____ State/Prov _____ Zip/P.C. _____

Spouse or Parent/Guardians Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____

Home Phone _____ Cell Phone _____

Email _____

Drivers License _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#SIN _____

Is this Person Currently a Patient in our Office Yes _____ No _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card Visa Mastercard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____

City _____ State/Prov _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____



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Insurance Company Address _____
 City _____ State/Prov _____ Zip/P.C. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following
 Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____
 City _____ State/Prov _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Insurance Company Address _____
 City _____ State/Prov _____ Zip/P.C. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	Yes	No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	Yes	No
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	Yes	No
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	Yes	No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	Yes	No
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	Yes	No
7. Do you use tobacco?	Yes	No
8. Do you use controlled substances?	Yes	No
9. Do you have or have you had any of the following?	Yes	No
High Blood Pressure	Yes	No
Heart Attack	Yes	No
Rheumatic Fever	Yes	No
Swollen Ankles	Yes	No
Fainting/Seizures	Yes	No
Asthma	Yes	No
Low Blood Pressure	Yes	No
Epilepsy/Convulsions	Yes	No



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Leukemia	Yes	No
Diabetes	Yes	No
Kidney Diseases	Yes	No
AIDS or HIV Infection	Yes	No
Thyroid Problem	Yes	No
Heart Disease	Yes	No
Cardiac Pacemaker	Yes	No
Heart Murmur	Yes	No
Angina	Yes	No
Frequently Tired	Yes	No
Anemia	Yes	No
Emphysema	Yes	No
Cancer	Yes	No
Arthritis	Yes	No
Joint Replacement or Implant	Yes	No
Hepatitis/jaundice	Yes	No
Sexually Transmitted Disease	Yes	No
Stomach Troubles/Ulcers	Yes	No
Chest Pains	Yes	No
Easily Winded	Yes	No
Stroke	Yes	No
Hay Fever/Allergies	Yes	No
Tuberculosis	Yes	No
Radiation Therapy	Yes	No
Glaucoma	Yes	No
Recent Weight Loss	Yes	No
Liver Disease	Yes	No
Heart Trouble	Yes	No
Respiratory Problems	Yes	No
Mitral Valve Prolapse	Yes	No
Other _____		
10. Are you wearing contact lenses?	Yes	No
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g Novocain)	Yes	No
Penicillin or any other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Any Metal (e.g. nickel, mercury, etc.)	Yes	No
Latex Rubber	Yes	No
Other _____		



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12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes	No
13. Women Only:		
Are you pregnant or think you may be pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking oral contraceptives?	Yes	No
Patient Dental History		
Name of Previous Dentist and Location _____ Date of Last Exam _____		
1. Do your gums bleed while brushing or flossing?	Yes	No
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
3. Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
4. Do you feel pain to any of your teeth?	Yes	No
5. Do you have any sores or lumps in or near your mouth?	Yes	No
6. Have you had any head, neck or jaw injuries?	Yes	No
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No
8. Do you have frequent headaches?	Yes	No
9. Do you clench or grind your teeth?	Yes	No
10. Do you bite your lips or cheeks frequently?	Yes	No
11. Have you ever had any difficult extractions in the past?	Yes	No
12. Have you ever had any prolonged bleeding following extractions?	Yes	No
13. Have you had any orthodontic treatment?	Yes	No
14. Do you wear dentures or partials? If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes	No
16. Do you like your smile?	Yes	No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of patient (or parent/guardian if minor)

Doctor's Comments

Signature _____ Date _____