

HAVE YOU BEEN A PATIENT IN THIS OFFICE BEFORE? \_\_\_\_\_ IF YES, WHEN? \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

SINGLE       MARRIED       DIVORCED       SEPARATED       WIDOWED

NAME OF SPOUSE \_\_\_\_\_

RESIDENCE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY, STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_ POSITION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ POSITION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

WHO WILL PAY THIS ACCOUNT? \_\_\_\_\_ REFERRED BY \_\_\_\_\_ MD  
 DDS

DO YOU HAVE DENTAL OR MEDICAL HEALTH INSURANCE? \_\_\_\_\_ IF YES, PLEASE COMPLETE THE BACK OF THIS FORM

SOCIAL SECURITY # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ STATE \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you been under the care of a medical doctor during the past two years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you taken any medicine or drugs during the past two years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been a patient in the hospital during the past two years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had any excessive bleeding requiring special treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you smoke? _____ How much? _____ For how long? _____   |                          |                          |

7. Circle any of the following which you have had or have at present:
- |                          |                   |                          |                            |
|--------------------------|-------------------|--------------------------|----------------------------|
| Heart Failure            | Kidney Trouble    | Xray or Cobalt           | Blood Transfusion          |
| Heart Disease or Attack  | Ulcers            | Chemotherapy (Cancer,    | Drug Addiction             |
| Angina Pectoris          | Ear Surgery       | Leukemia)                | Hemophilia                 |
| High Blood Pressure      | Emphysema         | Arthritis                | Veneral Disease (Syphilis, |
| Heart Murmur             | Cough             | Rheumatism               | Gonorrhoea)                |
| Rheumatic Fever          | Tuberculosis (TB) | Cortisone Medicine       | Cold Sores                 |
| Congenital Heart Lesions | Pneumonia         | Glaucoma                 | Genital Herpes             |
| Scarlet Fever            | Bronchitis        | Pain in Jaw Joints       | Epilepsy or Seizures       |
| Artificial Heart Valve   | Asthma            | Porphyria                | Fainting or Dizzy Spells   |
| Heart Pacemaker          | Hay Fever         | AIDS                     | Nervousness                |
| Heart Surgery            | Sinus Trouble     | Hepatitis A (infectious) | Psychiatric Treatment      |
| Artificial Joint         | Allergies/Hives   | Hepatitis B (serum)      | Sickle Cell Disease        |
| Anemia                   | Diabetes          | Liver Disease            | Bruise Easily              |
| Stroke                   | Thyroid Disease   | Yellow Jaundice          |                            |

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 8. Do you wear contact lenses?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you on a special diet?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has your medical doctor ever said you have a cancer or tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have any disease, condition, or problem not listed?    | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. WOMEN: Are you pregnant now?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you practicing birth control?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you anticipate becoming pregnant?                              | <input type="checkbox"/> | <input type="checkbox"/> |

13. Physician's name and phone number? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date

Signature of Patient

TED F. FEDER, D.D.S.  
9066 Tampa Avenue  
Northridge, CA 91324

**INSURANCE COVERAGE INFORMATION**

**FATHER'S INSURANCE COMPANY** \_\_\_\_\_

**ADDRESS OF INSURANCE COMPANY** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_

**GROUP #, CERT. #, OR SUBSCRIBER #** \_\_\_\_\_

**MEDICAL OR DENTAL** \_\_\_\_\_

**MOTHER'S INSURANCE COMPANY** \_\_\_\_\_

**ADDRESS OF INSURANCE COMPANY** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_

**GROUP #, CERT. #, OR SUBSCRIBER #** \_\_\_\_\_

**MEDICAL OR DENTAL** \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS:**

I authorize payment of medical and/or dental benefits to Ted F. Feder, D.D.S.,  
a Professional Corporation for services described.

\_\_\_\_\_  
Employee or Authorized Signature