TED F. FEDER, D.D.S.
9066 Tampa Avenue
Northridge, CA 91324
(818)993-3700

THE FOLLOWING INFORMATION IS FOR OUR RECORDS

PATIENT'S NAME________________________________DATE______________

HAVE YOU BEEN A PATIENT IN THIS OFFICE BEFORE?________IF YES, WHEN?______________

IF A CHILD, FATHER'S NAME____________________MOTHER'S NAME______________

PARENTS ARE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE

LEGAL GUARDIAN IF NOT LIVING WITH PARENTS________________________________

RESIDENCE ADDRESS____________________________PHONE______________

CITY, STATE____________________________________ZIP______________

FATHER EMPLOYED BY__________________________POSITION______________

BUSINESS ADDRESS____________________________PHONE______________

MOTHER EMPLOYED BY__________________________POSITION______________

BUSINESS ADDRESS____________________________PHONE______________

NEAREST RELATIVE NOT LIVING WITH YOU____________________________PHONE______________

ADDRESS____

PERSON RESPONSIBLE FOR THIS ACCOUNT______________________________

SOCIAL SECURITY #_____-_____-_____DRIVER'S LICENSE #______________STATE______

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

IF FULL TIME STUDENT, NAME OF SCHOOL______________CITY______________REFERRED BY______________ MD DDS

Age__________Date of birth______________________________

	YES	NO
1. Have you been under the care of a medical doctor during the past two years?	☐	☐
2. Have you taken any medicine or drugs during the past two years?	☐	☐
3. Have you been a patient in the hospital during the past two years?	☐	☐
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?	☐	☐
5. Have you ever had any excessive bleeding requiring special treatment?	☐	☐

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, Leukemia)	Drug Addiction
Angina Pectoris	Ear Surgery	Arthritis	Hemophilia
High Blood Pressure	Emphysema	Rheumatism	Veneral Disease (Syphilis, Gonorrhea)
Heart Murmur	Cough	Cortisone Medicine	Cold Sores
Rheumatic Fever	Tuberculosis (TB)	Glaucoma	Genital Herpes
Congenital Heart Lesions	Pneumonia	Pain in Jaw Joints	Epilepsy or Seizures
Scarlet Fever	Bronchitis	Porphyria	Fainting or Dizzy Spells
Artificial Heart Valve	Asthma	AIDS	Nervousness
Heart Pacemaker	Hay Fever	Hepatitus A (infectious)	Psychiatric Treatment
Heart Surgery	Sinus Trouble	Hepatitus B (serum)	Sickle Cell Disease
Artificial Joint	Allergies/Hives	Liver Disease	Bruise Easily
Anemia	Diabetes	Yellow Jaundice	
Stroke	Thyroid Disease		

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

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, Parent or Guardian (If minor, relationship)

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INSURANCE COVERAGE INFORMATION

INSURANCE CO. NAME ______________________________

INSURANCE CO. ADDRESS ______________________________

DATE OF BIRTH ______________________________

SOCIAL SECURITY # ______________________________

GROUP #, CERT. # OR SUBSCRIBER # ______________________________

MEDICAL OR DENTAL ______________________________

SPOUSE'S INSURANCE COMPANY:

NAME ______________________________

ADDRESS ______________________________

DATE OF BIRTH ______________________________

SOCIAL SECURITY # ______________________________

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.

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Employee or Authorized Signature