



**Patient Information**

Patient Name: \_\_\_\_\_  
Last First MI (Preferred Name)

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Method of Communication:  Email  Text  Cell#  Home#

**Parent/Spouse/Responsible Party Information**

Parent/Spouse Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Address(if different): \_\_\_\_\_  
Street City State Zip Code

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

**Primary Insurance Information:**

Dental Insurance through this company?:  Y  N

Insurer Name: \_\_\_\_\_ Employed By: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Address of Insurance: \_\_\_\_\_

Group Number: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

**Secondary Insurance Information**

Dental Insurance through this company?:  Y  N

Insurer Name: \_\_\_\_\_ Employed By: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Address of Insurance: \_\_\_\_\_

Group Number: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

**Who do you authorize Dr. Feuer and Dr. Genco Dental to speak with regarding your dental/financial information:**

Name(s): \_\_\_\_\_

**Whom shall we contact in case of emergency:** \_\_\_\_\_

Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.*

Signature of patient, parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Health History:**

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Are you allergic to any of the following?(please circle all that apply):**    **Yes**    **No**

Penicillin    Tetracycline    Sulfa Drugs    Aspirin    Codeine    Latex    Metals    Dental Anesthetics    Other \_\_\_\_\_

**Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.**

- |   |  |   |   |
|---|--|---|---|
| <b>Y N</b>  | <b>Y N</b>   | <b>Y N</b>  | <b>Y N</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease    | <input type="checkbox"/> <input type="checkbox"/> Valve Replacement     | <input type="checkbox"/> <input type="checkbox"/> Dizziness/Fainting        |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> <input type="checkbox"/> Asthma                 | <input type="checkbox"/> <input type="checkbox"/> Growths/Tumors        | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures         |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> <input type="checkbox"/> Hay Fever              | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders          |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> <input type="checkbox"/> Allergies              | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders/Anxiety |
| <input type="checkbox"/> <input type="checkbox"/> Stroke                  | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> <input type="checkbox"/> Jaundice              | <input type="checkbox"/> <input type="checkbox"/> Eating Disorders          |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> <input type="checkbox"/> Diabetes Type: _____   | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction/Alcohol    |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> <input type="checkbox"/> Blood Disease/Disorder | <input type="checkbox"/> <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> <input type="checkbox"/> Head Injuries             |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> <input type="checkbox"/> Menopause             | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches        |
| <input type="checkbox"/> <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> <input type="checkbox"/> Herpes Lesions         | <input type="checkbox"/> <input type="checkbox"/> Arthritis Type: _____ | <input type="checkbox"/> <input type="checkbox"/> Acid Reflux               |
| <input type="checkbox"/> <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> <input type="checkbox"/> Hepatitis Type: _____     |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                  | <input type="checkbox"/> <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> <input type="checkbox"/> Thyroid Type: _____   | <input type="checkbox"/> <input type="checkbox"/> HPV Virus                 |
| <input type="checkbox"/> <input type="checkbox"/> Cold Sores              | <input type="checkbox"/> <input type="checkbox"/> Cortisone Treatment    | <input type="checkbox"/> <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea               |
| <input type="checkbox"/> <input type="checkbox"/> History of Endocarditis | <input type="checkbox"/> <input type="checkbox"/> Lyme Disease           | <input type="checkbox"/> <input type="checkbox"/> Parkinson             |   |

**Joint Replacement:**  Y  N Type: \_\_\_\_\_ Date: \_\_\_\_\_ **Pre-Med Required:**  Y  N

**Cancer:**  Y  N Type: \_\_\_\_\_ Date: \_\_\_\_\_ Chemotherapy:  Y  N Radiation:  Y  N

**Do you have any other health problems or conditions?**  YES  NO

If yes, please explain: \_\_\_\_\_

**Are you taking any medications or vitamins at this time?**  YES  NO

If yes, please list medications/vitamins below:

_____	_____
_____	_____
_____	_____
_____	_____

**Have you been admitted to a hospital or needed emergency care during the past 5 years?**  YES  NO

If yes, please explain: \_\_\_\_\_

**Are you now under the care of a specialist?**  YES  NO Name of Physician: \_\_\_\_\_

**Do you smoke/use tobacco products?**  YES  NO Type: \_\_\_\_\_ How much per day?: \_\_\_\_\_

**WOMEN:**  N/A

**Are you pregnant or nursing?**  YES  NO Due Date: \_\_\_\_\_ **Are you taking birth control?**  YES  NO

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.*

**Signature of patient, parent or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_