1773 W. Fletcher Ave.
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Randy M. Feldman, D.D.S., M.S.
Orthodontic & Dentofacial Orthopedics

3739 Neptune St.
Tampa, FL 33612
(813) 254-8005

Since 1982

Welcome! Our specialty is creating beautiful, healthy smiles. To do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.

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NEW PATIENT FORM (18 & UP)

PATIENT INFORMATION

Patient's Legal Name: ______________________ **Preferred Name:** ______________

Today's date: ____/____/____ **Birthdate:** ____/____/____ **Age:** ______ **Sex:** M / F

Address: ______________________ **City, State, Zip:** ______________________

Home phone: ( ) ______________________ **Cell phone:** ( ) ______________________

Work phone: ( ) ______________________ **Email address:** ______________________

Brothers/Sisters or Sons/Daughters (names/ages): ______________________

Hobbies/Interests: ______________________ **School/ Grade:** ______________________

Previous orthodontic consultation? Yes / No **If so, when/where?** ______________________

Previous orthodontic treatment? Yes / No **If so, when/where?** ______________________

Reason for seeking orthodontic treatment? ______________________

How did you hear about our office?: (Please mark all that apply)

- ☐ Dentist Referral
- ☐ Dental Office Staff
- ☐ Location
- ☐ Reputation
- ☐ Smiles Across the Bay
- ☐ Feldman Website
- ☐ Invisalign Website
- ☐ Invisalign Commercial
- ☐ I am a Former Patient
- ☐ Newspaper/Magazine
- ☐ Phone Book
- ☐ Coupon in the Mail
- ☐ Other: ______________
- ☐ Transferring Orthodontist ______________
- ☐ I know a Feldman Orthodontic patient ______________ (Name)
- ☐ Feldman Staff Member ______________ (Name)
- ☐ Family Member ______________ ______________ (Name)

RESPONSIBLE PARTY INFORMATION ***REQUIRED**

Name: ______________________ **Rel. to pt.:** __________ **Marital Status:** S / M / W / D

Address: ______________________ **City, State, Zip:** ______________________

Home #: ( ) ______________________ **Work #:**( ) ______________________

Social Security: ____-____-____ **Drivers License #:** ______________ **Birthdate:** ____/____/____

Email address: ______________________ **Cell #:** ( ) ______________________

Employed By: ______________________ **Occupation:** ______________ **Years:** ______

Spouse's Name: ______________________ **Rel. to pt.:** ______________

Home #: ______) ______________________ **Work #:** ( ) ______________________

Social Security: ____-____-____ **Drivers License #:** ______________ **Birthdate:** ____/____/____

Employed By: ______________________ **Occupation:** ______________ **Years:** ______

Do you have orthodontic insurance coverage? Yes / No **If Yes, please fill out insurance form. Thanks!**

EMERGENCY INFORMATION

In case of emergency please contact ______________________________ **Phone (   )** ______________

Relationship to patient ____

DENTAL INFORMATION

How does the patient feel about wearing "braces/orthodontics"? ______________________

Does anyone else in the family need orthodontics? Yes / No If Yes, who? ______________

Dentist's Name: ______________________ **Does the patient receive regular checkups? Yes / No**

Last Dental Exam: ______________________ **Last Dental X-Rays:** ______________

Other Dental Specialists: ____________________________________

Have you been satisfied with past dentistry? Yes / No If No, please explain ______________

____

Does the patient currently have, or have had any of the following? (please circle)

Thumb/finger Habit	Head/neck injury
Nail biting	Jaw/joint pain/head/neck pain
Periodontal disease	Cold sores/clenching/grinding
Gum surgery/food traps	Adult/baby/wisdom tooth extractions

Is there any other dental information we should know about? ______________________

____

MEDICAL INFORMATION

Physician's Name: ______________________ **Patient's overall health: Excellent / Good / Poor**

Is the patient allergic to anything (drugs/food/pollen): ______________________

Is the patient currently under medical care? Yes / No Where/When? ______________

____

Is the patient currently taking medications? Yes / No Please list: ______________

Has the patient ever been hospitalized? Yes / No Where/When? ______________

Does the patient currently have, or have had any of the following? (please circle)

Adenoids removed	Drug history	Major surgery
AIDS (HIV)	Epilepsy/seizures	Nasal/airway problems
Arthritis	Heart problems	Sinus problems
Asthma	Hepatitis A, B, or C	Speech problems
Auto accident	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	Venereal disease

Is there any other medical information we should know about? ______________________

____

BENEFITS OF ORTHODONTICS

Your protected health information (PHI) may be used in connection with your treatment, payment on your account or health care operations. Our office will not disclose PHI except as otherwise required for treatment, diagnosis, and billing, the individual's rights and the practice's obligations.

Orthodontics is a service that provides an improvement in the appearance of the teeth, and general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I state that I have read and understand the above, and have truthfully to best of my ability answered all of the questions on this form.

Patient/Parent Signature: ______________________ **Date:** ______________

Thank you so much for taking your valuable time to fill out this form.