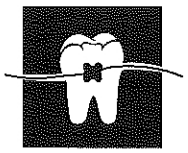

Francis J. Feeney

DMD MDS

ORTHODONTIST

(413) 547-0300

PATIENT INFORMATION & MEDICAL QUESTIONNAIRE

Patient's Name_____ Nickname _____
First Middle Last

Address_____

City_____State_____Zip_____Phone _____

Date of Birth_____ SS#_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hobbies_____

Employer_____ Work Phone _____

Name of Spouse_____ SS# _____

Spouse's Employer_____ Work Phone _____

Children (Names/Ages) _____

Name of Person(s) Financially Responsible For This Account _____

Address_____ Phone _____

Additional Person to Contact In An Emergency _____

Address_____ Phone _____

Name of Dentist_____ Address _____

Last Visit to Dentist_____ Last Dental Cleaning_____

Name of Physician_____ Address _____

Who referred you to our office?_____

Explain dentist's orthodontic concerns_____

Were you aware of any orthodontic problem prior to the referral? _____Explain your orthodontic concerns

_____

Has any other orthodontist been consulted?_____

Patient's general health: Excellent_____ Good_____ Fair_____ Poor_____

Does patient need to take **antibiotics** prior to a dental visit? Yes___ No ___

Does patient grind or clench teeth? Yes___ No ___

Does patient ever have stiff or tired jaw muscles? Yes___ No ___

Does patient's jaw "click, crack, or pop" upon opening or closing? Yes___ No ___