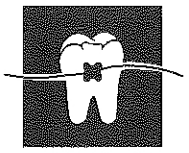

Francis J. Feeney

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 _____ Hobbies/Sports _____

School _____

Mother's Name _____ SS# _____ Occupation _____

Employer _____ Work Phone _____

Father's Name _____ SS# _____ Occupation _____

Employer _____ Work Phone _____

Other 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? _____

Were you aware of any orthodontic problem prior to the referral? _____

Explain patient's/parents' orthodontic concerns _____

Explain dentist's orthodontic concerns _____

_____

Has any other orthodontist been consulted? _____

Patient's general health: Excellent_____ Good_____ Fair_____ Poor_____