Stuart D. Greenberg, D.D.S.
ORTHODONTIST

PATIENT INFORMATION

This information is necessary for our files and will be considered confidential.

DATE ______________

PATIENT'S LAST NAME ______ FIRST NAME ______ MIDDLE ______ HOME PHONE ______

CURRENT STREET ADDRESS ______ CITY ______ STATE ______ ZIP ______

PATIENT'S BIRTHDATE ______ AGE ______ SEX ______ GENERAL DENTIST ______

IF A STUDENT, NAME OF SCHOOL/COLLEGE ______ WHOM MAY WE THANK FOR REFERRING YOU TO US ______

FAMILY INFORMATION

FATHER'S FULL NAME (Or Legal Guardian) ______ DRIVER'S LICENSE ______ BIRTHDATE ______

SOCIAL SECURITY NO. ______ ADDRESS ______ HOME PHONE ______ WORK PHONE ______

INSURANCE COMPANY NAME ______ GROUP OR UNION NAME ______ GROUP OR LOCAL NUMBER ______

EMPLOYER NAME ______ FULL ADDRESS OF EMPLOYER ______

HOW MUCH IS YOUR DEDUCTIBLE (?) ______ MAXIMUM BENEFIT(?) ______ DOES IT COVER ORTHODONTICS(?) ______

MOTHER'S FULL NAME (Or Legal Guardian 2) ______ DRIVER'S LICENSE ______ BIRTHDATE ______

SOCIAL SECURITY NO. ______ ADDRESS ______ HOME PHONE ______ WORK PHONE ______

INSURANCE COMPANY NAME ______ GROUP OR UNION NAME ______ GROUP OR LOCAL NUMBER ______

EMPLOYER NAME ______ FULL ADDRESS OF EMPLOYER ______

HOW MUCH IS YOUR DEDUCTIBLE (?) ______ MAXIMUM BENEFIT(?) ______ DOES IT COVER ORTHODONTICS(?) ______

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the orthodontic care for the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY ______ RELATIONSHIP TO PATIENT ______ DATE ______

PLEASE COMPLETE REVERSE SIDE

HEALTH QUESTIONNAIRE

NAME OF PHYSICIAN ____________ CITY ____________ DATE OF LAST PHYSICAL ____________

PLEASE "X" EACH BOX IF THE ANSWER IS "YES", LEAVE BLANK IF "NO"
HAVE YOU HAD...

☐ HEART PROBLEMS
☐ HIGH BLOOD PRESSURE
☐ LOW BLOOD PRESSURE
☐ BLOOD DISEASE
☐ HEART MURMER
☐ CIRCULATORY PROBLEMS
☐ RHEUMATIC FEVER
☐ HEPATITIS
☐ LIVER PROBLEMS
☐ DIABETES
☐ RADIATION TREATMENTS
☐ TONSILS REMOVED
☐ EPILEPSY
☐ KIDNEY PROBLEMS
☐ NERVOUS PROBLEMS
☐ TUBERCULOSIS
☐ EXCESSIVE BLEEDING
☐ CEREBRAL PALSY
☐ SCARLET FEVER
☐ TAKEN DIET PILLS fenfluramine/phentermine or dexfenflurmine (Redux)
☐ MALIGNANCIES
☐ ASTHMA
☐ CHRONIC SINUS
☐ CHRONIC EAR PROBLEMS
☐ ANEMIA
☐ ARTHRITIS
☐ ADENOIDS REMOVED
☐ A.I.D.S.
☐ H.T.L.V.
☐ H.I.V.
☐ VENEREAL DISEASE/HERPES

OTHER HEALTH COMPLICATIONS NOT LISTED ABOVE ____________

ARE YOU ALLERGIC TO

☐ PENICILLIN ☐ ASPIRIN ☐ LATEX

☐ OTHER ____________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ____________

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST TWO YEARS? IF YES, PLEASE EXPLAIN: ____________

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU FEEL THE DOCTOR SHOULD BE AWARE OF: ____________

HAVE YOU EVER BEEN HOSPITALIZED? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: ____________

IN CASE OF EMERGENCY, PLEASE CONTACT: ____________

ADDRESS ____________ CITY, STATE, ZIP ____________ PHONE ____________

STATE RELATIONSHIP (i.e., neighbor, friend, relative) ____________

SIGNATURE OF RESPONSIBLE PARTY ____________ RELATIONSHIP ____________ DATE ____________