

Comfort Dental of Clinton

PATIENT INFORMATION		
PATIENT NAME	GENDER: M F	FAMILY STATUS: M S C
BIRTHDATE	SSN	E-MAIL ADDRESS
HOME PHONE	WORK PHONE	CELL PHONE
ADDRESS		CITY,STATE,ZIP
EMERGENCY CONTACT (Not currently living with you)		RELATIONSHIP TO PATIENT
ADDRESS		PHONE #
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE OR WHERE DID YOU FIRST HEAR OF OUR OFFICE?		

RESPONSIBLE PARTY INFORMATION (only if patient is under 18)		
RESPONSIBLE PARTY'S NAME	GENDER: M F	FAMILY STATUS: M S C
BIRTHDATE	SSN	E-MAIL ADDRESS
HOME PHONE	WORK PHONE	CELL PHONE
ADDRESS		CITY,STATE,ZIP
EMPLOYER		EMPLOYER PHONE

DENTAL INSURANCE INFORMATION		
PRIMARY INSURANCE		
SUBSCRIBER NAME	BIRTHDATE	SSN
ADDRESS		CITY,STATE,ZIP
PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER		
NAME OF INSURANCE COMPANY		GROUP #
INSURANCE ADDRESS		CITY,STATE,ZIP
SUBSCRIBER'S EMPLOYER		
SECONDARY INSURANCE		
SUBSCRIBER NAME	BIRTHDATE	SSN
ADDRESS		CITY,STATE,ZIP
PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER		
NAME OF INSURANCE COMPANY		GROUP #
INSURANCE ADDRESS		CITY,STATE,ZIP
SUBSCRIBER'S EMPLOYER		

Patient's Health History

Name _____ Birthdate _____

Please list your Primary Care Physician: Name _____ Phone # _____

What is the date (or approximate date) of your last medical exam? _____

Would you consider yourself to be in fairly good health? Yes No If No, please explain: _____

Please list any medications (including birth control and herbal remedies) and why you are taking them: _____

If Yes, please explain: _____

Are you currently under the care of a physician due to a specific condition? Yes No

Have you had any changes in your health in the last year? Yes No

Have you been hospitalized within the last 5 years due to a surgery/illness? Yes No

Please indicate if you have ever experienced any of the following:

Please Explain: _____

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> *Pre-med – Amox | <input type="checkbox"/> *Pre-med – Clind | <input type="checkbox"/> *Pre-med – Other | <input type="checkbox"/> Allergy – Aspirin |
| <input type="checkbox"/> Allergy – Codeine | <input type="checkbox"/> Allergy – Erythro | <input type="checkbox"/> Allergy – Hay Fever | <input type="checkbox"/> Allergy – Latex |
| <input type="checkbox"/> Allergy – Other | <input type="checkbox"/> Allergy – Penicillin | <input type="checkbox"/> Allergy – Sulfa | <input type="checkbox"/> Anemia/Bleeding |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma/Resp Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease/Attack |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis/Liver Dis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |

Do you have any other conditions, diseases, allergies, etc., not listed above? _____

Please mark any of the following to indicate YES in response to the question:

If Yes, please explain: _____

- | | |
|---|--|
| <input type="checkbox"/> Do you smoke or use smokeless tobacco? | <input type="checkbox"/> Do you use alcohol? |
| <input type="checkbox"/> Have you ever had any drug addictions? | <input type="checkbox"/> Have you taken Phen-Fen or similar appetite suppressants? |
| <input type="checkbox"/> Taken Cortisone/Steroid medication? | <input type="checkbox"/> For Women Only: Are you pregnant? |
| <input type="checkbox"/> Taken Bisphosphonates? (ie. Fosamax, Actonel, Boniva, Aredia, Bonefos, Digronel, Zometa) | |

What is the reason for your dental visit today? _____

When did you last see a dentist? _____ Who was your previous dentist? _____ Phone _____

How frequently to you brush your teeth? 3(+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth? 1(+) a day 2-6 weekly 1-6 monthly Seldom Never

Please mark any of the following to indicate YES in response to the question:

If Yes, please explain: _____

- | | |
|--|--|
| <input type="checkbox"/> Are any of your teeth currently causing you pain? | <input type="checkbox"/> Do your gums bleed when you brush or floss? |
| <input type="checkbox"/> Do you currently have dental implants, dentures, or partials? | <input type="checkbox"/> Do you have any loose teeth? |
| <input type="checkbox"/> Do you grind your teeth (consciously or during sleep)? | <input type="checkbox"/> Are your teeth sensitive to hot or cold? |
| <input type="checkbox"/> Have you ever been diagnosed with periodontal disease? | |
| <input type="checkbox"/> Have you experienced problems with previous dental treatment or local anesthetic? | |

If you could change anything about your mouth, teeth, or smile, what would it be? _____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature: _____ Electronic Signature _____ Date: _____ On Electronic File _____ Relation to Patient: _____ On Electronic File _____