Comfort Care
Family Dental, P.C.

WELCOME

PATIENT INFORMATION

DATE_____

PATIENT_____SS#_____

ADDRESS_____CITY_____STATE_____ZIP_____

E-MAIL_____ SEX ☐ M ☐ F AGE_____ BIRTHDATE_____

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ MINOR ☐ SEPARATED ☐ DIVORCED ☐ PARTNERED FOR _____YEARS

OCCUPATION_____EMPLOYER/SCHOOL_____

EMPLOYER/SCHOOL ADDRESS_____

EMPLOYER/SCHOOL PHONE (_____)_____

SPOUSE'S NAME_____SS#_____BIRTHDATE_____

SPOUSE'S EMPLOYER_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PHONE NUMBER

HOME(_____)_____WORK(_____)_____CELL(_____)_____

SPOUSE'S WORK(_____)_____BEST TIME AND PLACE TO REACH YOU_____

IN CASE OF EMERGENCY, CONTACT(SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)

NAME_____ RELATIONSHIP_____

HOME PHONE(_____)_____ WORK PHONE(_____)_____

DENTAL HISTORY

REASON FOR TODAY'S VISIT_____

FORMER DENTIST_____CITY/STATE_____

DATE OF LAST DENTAL VISIT AND EXAM_____DATE OF LAST DENTAL X-RAYS_____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

BAD BREATH	☐ YES ☐ NO	FINGERNAIL BITING	☐ YES ☐ NO	ORTHODONTIC TREATMENT	☐ YES ☐ NO
BLEEDING GUMS	☐ YES ☐ NO	GRINDING TEETH	☐ YES ☐ NO	PAIN AROUND EAR	☐ YES ☐ NO
BLISTERS ON LIPS OR MOUTH	☐ YES ☐ NO	GUMS SWOLLEN OR TENDER	☐ YES ☐ NO	PERIODONTAL TREATMENT	☐ YES ☐ NO
BURNING SENSATION ON TONGUE	☐ YES ☐ NO	JAW PAIN OR TIREDNESS	☐ YES ☐ NO	SENSITIVITY TO COLD	☐ YES ☐ NO
CHEW ON SIDES OF MOUTH	☐ YES ☐ NO	LIP OR CHEEK BITING	☐ YES ☐ NO	SENSITIVITY TO HEAT	☐ YES ☐ NO
CIGARETTE, PIPE OR CIGAR SMOKING	☐ YES ☐ NO	LOOSE TEETH OR BROKEN FILLINGS	☐ YES ☐ NO	SENSITIVITY TO SWEETS	☐ YES ☐ NO
CLICKING OR POPING JAW	☐ YES ☐ NO	MOUTH BREATHING	☐ YES ☐ NO	SENSITIVITY WHEN BITING	☐ YES ☐ NO
DRY MOUTH	☐ YES ☐ NO	MOUTH PAIN, BRUISING	☐ YES ☐ NO	SORES OR GROWTHS IN YOUR MOUTH	☐ YES ☐ NO

HOW OFTEN DO YOU FLOSS?_____ HOW OFTEN DO YOU BRUSH?_____

MEDICATIONS

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING
AND THE CORRELATING DIAGNOSIS

_____

_____

_____

_____

PHARMACY NAME_____

ALLERGIES

☐ ASPIRIN ☐ BARBITURATES (SLEEPING PILLS) ☐ CODEINE
☐ IODINE ☐ LATEX ☐ LOCAL ANESTHETICS ☐ PENICILLIN
☐ SULFA ☐ OTHER_____

ARE YOU TAKING ANY BLOOD THINNERS? ☐ YES ☐ NO

IF "YES" PLEASE CHECK THE APPROPRIATE

☐ COUMADIN (WARFARIN) ☐ PLAVIX ☐ 81 mg ASPIRIN ☐ OTHER_____

PHARMACY PHONE NUMBER (_____)_____

HEALTH HISTORY

PHYSICIAN'S NAME_____ DATE OF LAST VISIT_____

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN"? THESE INCLUDE COMBINATIONS OF IONIMIN, ADIPEX, FASTIN (BRAND NAME OF PHENTERMINE), PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENLURAMINE). ☐ YES ☐ NO

PLACE A MARK OF "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	☐ YES ☐ NO	CORTISONE TREATMENT	☐ YES ☐ NO	JAW PAIN	☐ YES ☐ NO	SKIN RASH	☐ YES ☐ NO
ANEMIA	☐ YES ☐ NO	COUGH PERSISTENT OR BLOODY	☐ YES ☐ NO	KIDNEY DISEASE	☐ YES ☐ NO	SPECIAL DIET	☐ YES ☐ NO
ARTHRITIS, RHEUMATISM	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO	LIVER DISEASE	☐ YES ☐ NO	STROKE	☐ YES ☐ NO
ARTIFICIAL HEART VALVE	☐ YES ☐ NO	EMPHYSEMA	☐ YES ☐ NO	LOW BLOOD PRESSURE	☐ YES ☐ NO	SWOLLEN FEET OR ANKLES	☐ YES ☐ NO
ARTIFICIAL JOINTS	☐ YES ☐ NO	EPILEPSY	☐ YES ☐ NO	MITRAL VALVE PROLAPSE	☐ YES ☐ NO	SWOLLEN NECK GLANDS	☐ YES ☐ NO
ASTHMA	☐ YES ☐ NO	FAINTING OR DIZZINESS	☐ YES ☐ NO	NERVOUS PROBLEMS	☐ YES ☐ NO	THYROID PROBLEMS	☐ YES ☐ NO
BACK PROBLEMS	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO	PACEMAKER	☐ YES ☐ NO	TONSILLITIS	☐ YES ☐ NO
BLEEDING ABNORMALLY	☐ YES ☐ NO	HEADACHES	☐ YES ☐ NO	PSYCHIATRIC CARE	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO
BLOOD DISEASE	☐ YES ☐ NO	HEART MURMUR	☐ YES ☐ NO	RADIATION TREATMENT	☐ YES ☐ NO	TUMOR OR GROWTH ON	☐ YES ☐ NO
CANCER	☐ YES ☐ NO	HEART PROBLEMS	☐ YES ☐ NO	RESPIRATORY	☐ YES ☐ NO	ULCER	☐ YES ☐ NO
CHEMICAL DEPENDENCY	☐ YES ☐ NO	HEPATITIS TYPE____	☐ YES ☐ NO	RHEUMATIC FEVER	☐ YES ☐ NO	VENEREAL DISEASE	☐ YES ☐ NO
CHEMOTHERAPY	☐ YES ☐ NO	HERPES	☐ YES ☐ NO	SCARLET FEVER	☐ YES ☐ NO	WEIGHT LOSS, UNEXPLAINED	☐ YES ☐ NO
CIRCULATORY PROBLEMS	☐ YES ☐ NO	HIGH BLOOD PRESSURE	☐ YES ☐ NO	SHORTNESS OF BREATH	☐ YES ☐ NO	DO YOU WEAR CONTACT LENSES	☐ YES ☐ NO
CONGENITAL HEART LESIONS	☐ YES ☐ NO	JAUNDICE	☐ YES ☐ NO	SINUS TROUBLE	☐ YES ☐ NO		

WOMEN: ARE YOU PREGNANT? ☐ YES ☐ NO DUE DATE:_____ ARE YOU NURSING? ☐ YES ☐ NO TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

DENTAL INSURANCE

Who is responsible for this account?_____ Is Patient Covered by Additional Insurance? ☐ YES ☐ NO

Relationship to Patient_____ Subscriber's Name_____

Insurance Co._____ Birth Date _____SS#_____

Group Number_____ Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, undersigned certify that I (or my dependent) have insurance coverage with _____,and I assign directly to Comfort Care Family Dental, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____ _____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE