WELCOME

Please take a few minutes to fill out this form as completely as you can. Feel free to ask any questions.
We look forward to working with you on maintaining your dental health.

Patient Information

Date _____ Home Phone (_____)_____ Cell Phone (_____)_____

Name_____ Social Security # _____

Address _____ City _____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ Email_____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Other Occupation_____

Employer/School Address_____ Employer/ School Phone (_____) _____

Emergency Contact Information

Name _____ Relationship_____ Phone Number (_____)_____

Referral Information

How did you hear about us?

☐ Family member/ friend _____
☐ Internet
☐ Other _____
☐ Insurance company
☐ Mailed newsletter/ newspaper

Dental History

Reason for today's visit_____

Former dentist _____ Address _____

Date of last dental care/x-rays_____ How often do you brush? _____ How often do you floss? _____

Have you ever been pre-medicated prior to a dental procedure? ☐Yes ☐ No If yes, why?_____

Check (✓) if you have had problems with any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking/ popping jaw
☐ Food collection between teeth
☐ Grinding/ clenching teeth
☐ Jaw Pain
☐ Loose teeth or broken fillings
☐ Periodontal therapy
☐ Sensitivity to biting
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sores/ lumps in mouth
☐ Other _____

Medical History

Physician's Name_____ Date of last visit_____

Pharmacy Name _____ Address_____ Phone (_____)_____

Have you had any serious illnesses or operations? ☐Yes ☐ No If yes, describe_____

Have you ever had a blood transfusion? ☐Yes ☐ No If yes, approximate dates _____

(Women) Are you pregnant? ☐Yes ☐ No Nursing? ☐Yes ☐ No Taking birth control pills? ☐Yes ☐ No

Medical History

Check (✓) if you have had problems with any of the following:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
  Type _____
- ☐ Chemotherapy
- ☐ Chest pain
- ☐ Circulatory problems
- ☐ Cold sores
- ☐ Diabetes
  Type_____
  Date of last A1c_____
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Depression
- ☐ Drug addiction
- ☐ Epilepsy/ seizures
- ☐ Fainting/ dizziness
- ☐ Gastrointestinal disease (GERD)
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart attack/ failure
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Hemophilia
- ☐ Hepatitis
  Type_____
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/ AIDS
  Date of labwork_____
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Mitral valve prolapse
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Tobacco use
  Current user: Type_____
  How much/day? _____ How long? _____
  Former User: When did you quit? _____
- ☐ Radiation
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus issues
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Ulcers
- ☐ Venereal disease

Have you ever taken any bone density "bisphosphonates" medication (Fosamax, Boniva, Zometa, Reclast, Xgeva)?
☐Yes ☐ No If yes, for how long?_____

ALLERGIES ☐Yes ☐ No If yes, please list_____

MEDICATIONS ☐Yes ☐ No If yes, please list_____

_____

_____

_____

_____

Office Policy

When we reserve time for you, we want all that time to provide you with the best quality work possible. We require a **48 hour notice** if you cannot make your scheduled appointment time to avoid a missed appointment fee and/or dismissal from the practice. If you are more than **15 minutes late** for your appointment, you may be asked to reschedule.

Please initial that you have read and understand our office policy: _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assigned directly to Dr. Anthony Petrilli (Comfort 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. Payment is due in full at the time of treatment unless prior arrangements have been approved. I authorize the use of my signature on all insurance submissions.

The above-named dentist and his associates may use my healthcare information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or for the benefits payable for related services. This content of discloser also extends to the purposes of collecting any debt incurred on my (or dependents) behalf should I fail to keep my (our) account current with Comfort Dental.

Print Name of Patient/ Guardian _____ Date_____

Signature of Patient/ Guardian _____ Date_____