info@comfodent.com

www.comfodent.com

Today's Date: . . . .

Personal Information			
First Name	Last Name	Preferred Name	
Address			
Apt#	Town/City	Postal Code	
Cell Phone	Home Phone	Work Phone	Other Phone . . . .
Email Address	Date of Birth	Female / Male	Age . . . .
Employed by:	Care Card Number		
Emergency Contact . . . . Name	Relationship	Phone Number	
How did you hear about our office? If you are referred by another patient, please mention their names.			

Insurance Information	
Primary	**Secondary**
Insurance Company	Insurance Company . . . .
Employer	Employer . . . .
Policy Holder Name and Relationship	Policy Holder Name and Relationship . . . .
Policy Holder Date of Birth	Policy Holder Date of Birth . . . .
Group Number	Group Number . . . .
ID Number	ID Number . . . .

Medical History

Family Physician's Name	Phone Number

1. Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No Please explain:
. . . .
2. **Are you taking any medication, drugs or pills?** □ Yes □ No If yes, please list names and dosage:
. . . .
3. **Are you aware of having an allergy/reaction to any medication or substance?** □ Yes □ No If yes, please list:
. . . .
4. Do you need Antibiotics before Dental treatment? □ Yes □ No Please explain: . . . .
5. Do you smoke? (Indicate what) . . . .
6. Please use a checkmark to indicate which of the following disease(s) you have had:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Disease			AIDS / HIV			Hay Fever			Radiation Therapy		
High Blood Pressure			Hepatitis A, B, C, D			Diabetes			Lung disease		
Heart Surgery / Attack			Anemia			Stroke			Liver Disease		
Artificial Heart Valve			Hemophilia			Sinusitis			Kidney Trouble		
Artificial Joints			Asthma			Rheumatic Fever			Epilepsy / Seizures		
Cancer / Tumor			Latex Sensitivity			Chemotherapy			Tuberculosis		

7. Do you have any disease or condition that is not listed above? □ Yes □ No Please explain:
. . . .

Treatment recommendations are based on your dental health needs, not dictated by your dental coverage. Due to the government's legislation on personal privacy, the office may be unable to obtain the details of your dental insurance. It is your responsibility to know your plan coverage. However, we will help you understand your coverage and assist you in obtaining pre-authorizations for treatment. As a service to our patients, the office will bill your insurance directly. Any services not covered by your plan will be collected at the time treatment is provided. Thank you for your understanding. If you have any questions, feel free to ask the front staff.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurances carriers, payors, and/or healthcare practitioners. Should further information be needed, ComfoDent dental group has my permission to ask the respective health care provider or agency, which may release such information to them. I authorize my insurance carrier to submit payment directly to the dentist and to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance.

I authorize the diagnosis of my dental health by means of radiographs, study models, photos, or other diagnostic aids deemed appropriate. Upon such diagnosis, I authorize the doctor and his/her team to perform all recommended treatment. I understand that possibility of complication exists for each treatment and I can ask for a complete recital of any possible complications. I certify that all the medical, dental and insurance information provided is correct and I agree to inform the staff and doctors of any changes.

------------------------------------- Relationship to the patient: . . . . Date: . . . .

Patient/Guardian Signature

Dental History

Previous Dentist's Name	Phone Number
Reason for your visit today:	
When was your last dental visit? What was done at that time?	When were your last x-rays taken?
When was your last dental hygiene/cleaning?	How often do you brush?
How frequently do you see your hygienist?	How often do you floss?

Please use a checkmark to answer the following questions:

Condition	Yes	No	Condition	Yes	No
Are you satisfied with the appearance of your teeth?			Would you like us to discuss sedation options with you to make your treatment more comfortable?		
Do your gums bleed or hurt?			Have you ever had difficulty with opening or closing your mouth?		
Have you noticed any mouth odor or bad taste?			Do you clench / grind your teeth while awake/asleep?		
Do you have gum recession?			Have you ever had clicking or popping of the jaws?		
Have you ever had surgery on your gums?			Do you have tired / sore jaws in the morning?		
Do you feel nervous about dental treatment?			Do you have a Night Guard?		
Have you ever had sedation for dental treatment?			Do you smoke?		

-Do you have any concerns about your mouth?

-Are you satisfied with your smile? If No, what would you change?

-What concerns you most about receiving dental treatment?

-Why did you leave your last dental office?

-What would you change about your last dental office?

-How did you hear about our office? What made you come to our office?

-What are you looking for in a dental office?

-Is there anything else regarding your dental treatment that we have to know?