Dr. Laura M. Comeau, DDS

2100 Calle de la Vuelta, E105
Santa Fe, NM 87505
(505)-570-9578

PATIENT INFORMATION — Today's Date:

Name_____Birth date____-____-_____SS#____-_____-____

Address_____City_____State_____Zip_____

Sex___ M___ F ___Married ___Widowed ___Single ___Partnered
___Separated ___Divorced ___Minor

Home phone #_____ Cell phone #_____Other phone #_____

Employer_____Work phone #_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone #_____

RESPONSIBLE PARTY

Person responsible for account_____ Relation to patient_____

Address_____ Home phone #_____

Birth date_____ Currently a patient in our office? Y / N

Employer_____ Work phone #_____

Email_____ Cell phone #_____

INSURANCE INFORMATION

Name of insured_____

Birth date_____SS#_____ Relation to patient_____

Employer_____Work phone #_____

Employer address_____City_____ State_____Zip_____

Insurance company_____Phone #_____ Group #_____

Address_____City_____State_____ Zip_____

ADDITIONAL INSURANCE

Name of Insured_____

Birth date_____SS#_____Relation to patient_____

Employer_____Work phone #_____

Employer address_____City_____ State_____Zip_____

Insurance company_____Phone #_____Group #_____

Address_____City_____ State_____Zip_____

DENTAL HISTORY

Reason for today's visit_____Date of last dental care_____
Former dentist _____ Date of last dental X-ray_____
Check the box if you have had problems with any of the following:

- □ Bad breath
- □ Bleeding gums
- □ Clicking or popping jaw
- □ Food collecting between teeth
- □ Grinding teeth
- □ Loose teeth
- □ Broken fillings
- □ Periodontal treatments
- □ Sensitivity to sweets
- □ Sensitivity to cold/hot
- □ Dental anxiety
- □ Sensitivity when biting
- □ Sores or growths in your mouth

MEDICAL HISTORY

Physician's name_____Date of last visit_____
Have you ever taken any of the medications referred to as "Bisphosphonates"? These include Fosamax, Actonel, Atelvia, Didronel, Boniva _____Yes ____No. If yes, name of drug and duration of treatment_____
(Women) Are you Pregnant?____Yes____No. Nursing?____Yes____No. Taking birth control pills? ____Yes_____No
Check the box if you have or have had problems with any of the following:

- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial heart valves
- □ Artificial joints, pins
- □ Asthma
- □ Bleeding abnormally
- □ Blood disease
- □ Cancer
- □ Chemical dependency
- □ Chemotherapy
- □ Circulatory problems
- □ Congenital heart lesions
- □ Cortisone treatment
- □ Cough (persistent)
- □ Coughing blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Herpes
- □ Heart murmur
- □ Hemophilia
- □ Hepatitis
- □ High blood pressure
- □ HIV/AIDS
- □ Jaw pain
- □ Kidney disease
- □ Liver disease
- □ Mitral valve prolapse
- □ Osteoporosis
- □ Pacemaker
- □ Radiation treatment
- □ Respiratory disease
- □ Rheumatic fever
- □ Scarlet fever
- □ Shortness of breath
- □ Skin rash
- □ Stroke
- □ Swelling of feet or ankles
- □ Thyroid problems
- □ Tuberculosis
- □ Ulcer
- □ Venereal disease

Surgery or illnesses not listed? _____
List any medications you are currently taking_____
Allergies: _____None

- □ Aspirin
- □ Barbiturates (Sleeping pills)
- □ Codeine
- □ Local anesthetic
- □ Penicillin
- □ Sulfa
- □ Iodine
- □ Latex
- □ Other:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I (or my child) ever have a change in health.

____I give consent to have diagnostic radiographs taken.

_____ _____
Signature of the patient, parent or guardian Date

_____ _____
Please print name of patient, parent or guardian Date

OFFICE USE ONLY MEDICAL UPDATE

Date	Changes	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____