Laura Comeau, DDS
FAMILY, RESTORATIVE & COSMETIC DENTISTRY

PATIENT INFORMATION FORM

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_____

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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_____

MEDICAL INFORMATION

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:

- ☐ Acid Reflux
- ☐ 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
- ☐ GERD
- ☐ 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
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease

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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 filling
- ☐ Periodontal treatment
- ☐ Sensitivity to sweets
- ☐ Sensitivity to cold/hot
- ☐ Dental anxiety
- ☐ Sensitivity when biting
- ☐ Sores to growths in your mouth

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***	***Signatures***
_____	_____	_____
_____	_____	_____
_____	_____	_____

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