



comal dental

family · cosmetic · implant

Welcome to our office! To assist us in serving you, please complete the following confidential forms

The information provided is important to your dental health.

Patient name _____ Birth date _____

If minor, parents names _____

Cell phone _____ Home phone _____

Work phone _____ Email Address _____

Mailing address _____

Emergency Contact name _____ Phone _____

Employer _____ Occupation _____

Whom may we thank for referring you to our office _____

BILLING AND INSURANCE INFORMATION Not covered by dental insurance

Subscriber name _____ Subscriber SS# or ID# _____

Group number _____ Date of birth _____

Employer _____ Dental Insurance Co. _____

Insurance Co. phone _____

Secondary dental insurance YES NO

Subscriber name _____ Subscriber SS# or ID# _____

Group number _____

Employer _____ Dental Insurance Co. _____

Insurance Co. phone _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis or gout _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____			28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin _____			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin _____			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline _____			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa _____			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic _____			33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride _____			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> chlorhexidine (CHX) _____			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iodine _____			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			37. STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex _____			38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> nuts _____			39. HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fruit _____			40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> milk _____			41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> red dye _____			42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment or antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	45. concentration problems or ADD/ADHD _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
8. heart murmur, rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements, vitamins, and/or probiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches or chronic pain _____	<input type="checkbox"/>	<input type="checkbox"/>
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. chronic ear infections, tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease or jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	58. diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>
19. vertigo (e.g. "the room is spinning") _____	<input type="checkbox"/>	<input type="checkbox"/>			
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____	<input type="checkbox"/>	<input type="checkbox"/>			
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>			
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>			
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____