

# HEALTH HISTORY

*To ensure your safety during ComfortCare Dental procedures, please provide the following information:*

Name of Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Name of Specialty Physician(s) \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ Phone \_\_\_\_\_

**Do you currently have, or have you had in the past, any of the following? Please check Yes (Y) or No (N).**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Positive        | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> <input type="checkbox"/> Operations/Surgery        |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease      | <input type="checkbox"/> <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> <input type="checkbox"/> Organ Transplant          |
| <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis              | <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care          |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                   | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment       |
| <input type="checkbox"/> <input type="checkbox"/> Angina                   | <input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> <input type="checkbox"/> Renal Dialysis            |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse            | <input type="checkbox"/> <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis                | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> <input type="checkbox"/> Shingles                  |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                   | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease       |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion        | <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> <input type="checkbox"/> Steroid Medication        |
| <input type="checkbox"/> <input type="checkbox"/> Cancer                   | <input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> <input type="checkbox"/> Stomach/Intestine Disease |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> <input type="checkbox"/> Joint replacement     | <input type="checkbox"/> <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease           |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Medication     | <input type="checkbox"/> <input type="checkbox"/> Leukemia              | <input type="checkbox"/> <input type="checkbox"/> Tobacco Use               |
| <input type="checkbox"/> <input type="checkbox"/> Depression/Anxiety       | <input type="checkbox"/> <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> <input type="checkbox"/> Ulcers/Reflux Disease     |
| <input type="checkbox"/> <input type="checkbox"/> Drug Addiction           | <input type="checkbox"/> <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures        | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Other                     |

**Please explain any illness you checked Yes to:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Do you require antibiotic medication before dental appointments?  
  Are you taking or have you taken any medications for Osteoporosis, Osteopenia or low bone density?  
  Are you allergic to latex?  
  Are you allergic to any medications or substances? If yes, please list: \_\_\_\_\_

**Women:**  
  Are you Pregnant? If yes, number of weeks \_\_\_\_\_   Are you trying to get pregnant?  
  Taking Oral Contraceptives?

**Please list all current medications and supplements:**

| Drug  | Purpose | Drug  | Purpose |
|-------|---------|-------|---------|
| _____ | _____   | _____ | _____   |
| _____ | _____   | _____ | _____   |
| _____ | _____   | _____ | _____   |
| _____ | _____   | _____ | _____   |

I understand the above information to be true to the best of my knowledge and will make this office aware of any changes as soon as possible. I authorize ComfortCare Dental to administer medications and perform procedures necessary for proper care.

\_\_\_\_\_  
 Patient Signature (or parent/guardian)                      Patient Name (please print)                      Date



*Thank you for choosing us as your dental providers. We are dedicated to providing you with the most comfortable, quality, state-of-the-art dental care available.*

**Please Complete the Following:**

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

What is the best number to call for appointment confirmation? \_\_\_\_\_

Person to contact in case of emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Comfort Care Dental? \_\_\_\_\_

Do you have dental insurance? Yes No Insurance Provider \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Policy number \_\_\_\_\_

**Dental History**

Is there anything you would like the dentist to pay special attention to? Yes No

If yes please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you happy with your smile? Yes No

Do you have dental fear or phobia? Yes No

We understand that you may need to make changes to your appointment at times. However, in consideration of other scheduled patients, we require a 48 hour notice to do so. Thank you for your cooperation.

*Please complete other side*