

J. Brett Comstock, DDS Oral and Maxillofacial Surgery

Date_____

Patient Name_____

Last Name

First Name

Initial

Preferred Name

Address:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____ Cell Phone Number_____

Date of Birth: ____/____/____ Age_____ E-mail Address_____

Single () Married () Widowed () Have you seen our website, drbrettcomstock.com? Yes / No

Name of Employer : _____ Occupation:_____ Work Phone:_____

Employer Address:_____ Social Security Number: ____/____/____

Spouses Name:_____ Date of Birth ____/____/____ Employer:_____

In case of emergency, who should we notify?_____ Phone:_____ Relationship_____

Whom may we thank for referring you to us?_____

Family Physician:_____ Phone:_____ Family Dentist:_____ Phone_____

Who is financially responsible for this bill? _____ Relationship to patient_____

Address (if information is not provided above):_____

Street

City

State

Zip

Financially responsible person's phone: Home_____ Work _____

Insurance Information

Primary Dental Insurance Name:_____ **Address:**_____ **Phone:**_____

Name of Policy Holder_____ Relationship_____ Birthdate_____

ID or SS Number:_____ Group Number:_____ Employer:_____

Secondary Dental Insurance Name:_____ **Address:**_____ **Phone:**_____

Name of Policy Holder_____ Relationship_____ Birthdate_____

ID or SS Number:_____ Group Number:_____ Employer:_____

Primary Health Insurance Name:_____ **Address:**_____ **Phone:**_____

Name of Policy Holder_____ Relationship_____ Birthdate_____

ID or SS Number:_____ Group Number:_____ Employer:_____

HEALTH HISTORY

Patient's Name	Age	Date
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Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health?Y N
2. Has there been any change in your general health in the past year?..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?..... Y N
If yes, what problem _____
5. Have you ever had any serious illnesses, operations, or hospitalizations? If so, please describe

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
 - A. Rheumatic Fever or Rheumatic Heart DiseaseY N
 - B. Congenital Heart Disease?.....Y N
 - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?.....Y N
 - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?.....Y N
 - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?.....Y N
 - F. Bleeding Disorder, Anemia, Bleeding Tendency Blood Transfusion? Do you bruise easily?..... Y N
 - G. Liver Disease (Jaundice, Hepatitis)?..... Y N
 - H. Kidney Disease?..... Y N
 - I. Diabetes?..... Y N
 - J. Thyroid Disease?..... Y N
 - K. Arthritis?..... Y N
 - L. Stomach Ulcers or Colitis.....Y N
 - M. Glaucoma?..... Y N
 - N. Osteoporosis?..... Y N
 - O. Radiation.....Y N
 - P. Implants placed anywhere in your body? Heart Valve, Pacemaker, Hip, Knee)..... Y N
 - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.... Y N
 - R. Sinus or Nasal problems.....Y N
 - S. Any disease, drug, or transplant operation that has depressed your immune system..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
 - A. Antibiotics?..... Y N
 - B. Anticoagulants (Blood Thinners)?..... Y N
 - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?..... Y N
 - D. High Blood Pressure medications..... Y N
 - E. Steroids (Cortisone, etc.)?.....Y N
 - F. Tranquilizers..... Y N
 - G. Insulin or Oral Anti-Diabetic drugs..... Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart medication?..... Y N
- I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)?..... Y N
- J. Please list any and all medications taken, including prescription medications, diet drugs over the counter medications, herbal or holistic Remedies, vitamins or minerals :

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
 - A. Local Anesthesia (Novocain, etc.)?..... Y N
 - B. Penicillin or other antibiotics?..... Y N
 - C. Sedatives, Barbiturates?..... Y N
 - D. Aspirin or ibuprofen?..... Y N
 - E. Codeine or other pain killers?..... Y N
 - F. Latex or Rubber Products?.....Y N
 - G. Other Allergies or reactions? Please list..... Y N
10. Do you smoke or chew tobacco?..... Y N
How much per day?_____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide for you?..... Y N
12. Have you had any serious problems associated with any previous dental treatment?..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N
15. Do you wish to talk to the doctor privately about anything?..... Y N
16. Do you drink Alcohol?..... Y N
How often?_____ How Much?_____
17. **FOR WOMEN ONLY**
 - A. Are you Pregnant, or **is there any chance** you might be pregnant?.....Y N
 - B. Are you nursing?..... Y N

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Please sign after you have had the opportunity to discuss your health history with the doctor.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date	Signature of Person Completing Health History	Doctor's Initials
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