

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 : _____

Date of Birth: ____/____/____

Single () Married () Widowed () Separated () Divorced ()

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: _____

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): _____
City State Zip

Financially responsible person's phone: Home _____ Work _____

Insurance Information

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

Name of Employee: _____ Relationship: _____ Birthdate: _____

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

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

Name of Employee: _____ Relationship: _____ Birthdate: _____

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

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

Name of Employee: _____ Relationship: _____ Birthdate: _____

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

(PLEASE CONTINUE TO NEXT PAGE)

Please answer each question below. Answer yes or no. Complete & accurate information is necessary to insure appropriate treatment. Your answers are for our records only and will be held in the strictest of confidence.

Sex: M F Age _____ Height _____ Weight _____

Date of last Physical Exam _____ *Women only*, Are you, or do you think you may be pregnant? _____

Do you smoke tobacco? _____ Chew tobacco _____ How Long? _____ How much _____

Do you drink alcohol? _____ How often? _____ How Long? _____ How Much? _____

Are you NOW under the care of a physician? _____ For what? _____

Has there been ANY change in your health in the last year? _____ What? _____

List all past surgeries: _____

List all past hospitalizations: (other than for surgeries) _____

Are you allergic to any medications? Give names and dosages _____

Do you take ANY drugs? (Prescription or non-prescription) Give names and dosages _____

General Health is: Excellent () Good () Poor ()

HAVE YOU EVER HAD OR DO YOU HAVE ---- (Please check those applicable below)

| Yes | No | | Yes | No | |
|-----|-----|--|-----|-----|-----------------------------------|
| ___ | ___ | Rheumatic Fever | ___ | ___ | Diabetes |
| ___ | ___ | Heart Disease | ___ | ___ | High Blood Sugar |
| ___ | ___ | Heart Attack | ___ | ___ | Low Blood Sugar |
| ___ | ___ | Heart Murmur | ___ | ___ | Seizures or Epilepsy |
| ___ | ___ | Angina (chest pain) | ___ | ___ | Hyperthyroid |
| ___ | ___ | Stroke | ___ | ___ | Hypothyroid |
| ___ | ___ | High Blood Pressure | ___ | ___ | Ulcers |
| ___ | ___ | Anemia | ___ | ___ | Kidney Disease |
| ___ | ___ | Unusual Bleeding | ___ | ___ | Arthritis or Bursitis, Rheumatism |
| ___ | ___ | Problems with Eyes (infection,glaucoma) | ___ | ___ | Cancer Therapy or Treatment |
| ___ | ___ | Problems with Temporomandibular Joints | ___ | ___ | Steroid or Cortisone Therapy |
| ___ | ___ | Sinus Problems | ___ | ___ | Blood Transfusions |
| ___ | ___ | Problems with Throat | ___ | ___ | HIV Positive |
| ___ | ___ | Breathing Problems | ___ | ___ | AIDS |
| ___ | ___ | Emphysema | ___ | ___ | Venereal Disease |
| ___ | ___ | Asthma | ___ | ___ | Drug Dependency |
| ___ | ___ | Liver Disease | ___ | ___ | Alcoholism |
| ___ | ___ | Hepatitis or Jaundice | | | |

Have YOU or ANY member of your family had an adverse reaction to General Anesthesia? _____

Is there any disease, condition or problem not mentioned above that you think I should know about? _____

The above statements are true and correct to the best of my knowledge.

Signature of Patient or Parent: _____ Date: _____

Signature of Doctor: _____ Date: _____