# TODAY'S FAMILY DENTAL – HARVEY B. COMRIE, DDS P.C.
## Confidential Patient Information

(Please print legibly) Date: _____

### PERSONAL INFORMATION

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ (E-Mail) _____

Birthdate: _____ Sex: _____ Martial Status _____ Spouse Name _____

Occupation: _____ Referred by: _____

### PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

### DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS #: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS#: _____

Employer: _____ Policy #: _____

**I understand that payment is my obligation regardless of insurance or any other third-party involvement.**

**SIGNATURE:** _____ **DATE:** _____

## Confidential Patient Information

(Please print legibly)

Patient Name: _____ Initial Date: _____

Updated: _____ Updated: _____

Updated: _____ Updated: _____

### HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

Yes ___ No __ 1. Have you been hospitalized within the past 2 years? For what? _____

Yes ___ No __ 2. Are you currently being treated by a physician? For what? _____

Yes ___ No __ 3. Are you currently taking any medicines or drugs? What? _____

_____

Yes ___ No __ 4. Have you ever received counseling for excessive use of alcohol/prescription drugs?

Yes ___ No __ 5. Are you allergic to any drugs? What? _____

Yes ___ No __ 6. Have you ever had a skin rash or other reaction to metal jewelry? To What?_____

Yes ___ No __ 7. Are you allergic to any metals? What? _____

Yes ___ No __ 8. Do you bleed excessively upon injury?

Yes ___ No __ 9. Are you pregnant?

Yes ___ No __10. Have you ever been involved with dental/medical legal activity?

### CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

| | | | |
|---|---|---|---|
| A. Aids | F. Epilepsy | K. High Blood Pressure | P. Rheumatic Fever |
| B. Arthritis | G. Glaucoma | L. Jaundice | Q. Sexually Transmitted Diseases |
| C. Asthma | H. Heart Murmur | M. Kidney Problems | R. Stroke |
| D. Cancer | I. Heart Problem* | N. Low Blood Pressure | S. Tuberculosis |
| E. Diabetes | J. Hepatitis | O. Nervous Breakdown Or Psychiatric Therapy | T. Other Diseases* |

*If you circled either I or T describe condition: _____

### PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN A RELATIVE)

Name: _____ Phone: (Home)_____(Work)_____

Address: _____

**Patient Signature**:_____ **Date**: _____