Comfort Dental
1014 South 320th St., Ste E
Federal Way, WA 98003
253-529-0123

Medical Alert For Office Use

Thank you for visiting Comfort Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____

Mobile(____) _____ ❑ Male ❑ Female

Emergency: Name _____ Phone (____) _____

Insurance

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

_____

Have your teeth ever embarrassed you in the last year? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

What did you like *least* about your last dentist? _____

Medical History and Information

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other _____

Are you allergic to?

- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Penicillin
- ❑ Latex
- ❑ Local anesthetic
- ❑ Other _____

Are you currently under the care of a physician?

❑ Yes ❑ No

Please explain: _____

_____

Female Patients: Are you pregnant? ❑ Yes ❑ No

If yes, when is your due date? _____

CURRENT MEDICATION TAKEN _____

_____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE