Welcome to our practice!

# COMPTON DENTAL

Family and Cosmetic Dentistry

ALEX COMPTON, DMD

Please take a few minutes to answer the following questions so we can better assist you with your needs.

## PATIENT INFORMATION

Date ____________ Soc. Sec. # ____________ Birthdate ____________

Name ____________ Home Phone ____________
Last Name First Name Middle Initial

Address ____________ Cell Phone ____________

City ____________ State ______ Zip ______ Email ____________

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer ____________ Bus. Phone ____________

Business Address ____________ Occupation ____________

How did you hear about us? ____________

In Case of Emergency Please Contact ____________ Phone ____________

## PRIMARY DENTAL INSURANCE

Person Responsible for Account ____________
Last Name First Name Middle Initial

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Responsible Party Employed By ____________ Bus. Phone ____________

Business Address ____________ Occupation ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D.# ____________ Group # ____________

## SECONDARY DENTAL INSURANCE

Insured Name ____________
Last Name First Name Middle Initial

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Insured Employed By ____________ Bus. Phone ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D.# ____________ Group # ____________

Please Complete Reverse Side

# DENTAL HISTORY

Former Dentist ______________________________

City, State ______________________________

Date of Last Dental Visit ______________________________

Date of Last X-Rays ______________________________

How Often Do You Floss? ______________________________

How Often Do You Brush? ______________________________

Please Check All That Apply:

- Bad Breath ❑
- Bleeding Gums ❑
- Blisters on Lips/Mouth ❑
- Finger Nail Biting ❑
- Grinding Teeth ❑
- Lip or Cheek Biting ❑
- Loose Teeth or Broken Fillings ❑
- Orthodontic Treatment ❑
- Pain Around Ear ❑
- Periodontal Treatment ❑
- Sensitivity to Cold ❑
- Sensitivity to Heat ❑
- Sensitivity to Sweets ❑
- Sensitivity When Biting ❑
- Frequent Headaches ❑
- Jaw, Head & Neck Injuries ❑
- Jaw Difficulty: Clicking and/or Pain ❑
- Tooth Pain ❑

# MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ______________________________

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment | ❑ | ❑ |
| 2. Have you ever had any serious illness or operations? | ❑ | ❑ |
| 3. Are you currently taking any medications? | ❑ | ❑ |
| If so, please describe ______________________________ | | |
| 4. Do you smoke? | ❑ | ❑ |
| 5. Do you use alcohol, cocaine or other drugs? | ❑ | ❑ |
| 6. Do you wear contact lenses? | ❑ | ❑ |

7. Have you had any allergic reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. Novocaine) | ❑ | ❑ |
| Penicillin or other Antibiotics | ❑ | ❑ |
| Sulfa Drugs | ❑ | ❑ |
| Barbiturates (Sleeping Pills) | ❑ | ❑ |
| Sedatives | ❑ | ❑ |
| Latex | ❑ | ❑ |
| Iodine | ❑ | ❑ |
| Aspirin | ❑ | ❑ |
| Other | ❑ | ❑ |

8. (Women only) Are You:

| | Yes | No |
|---|---|---|
| Pregnant? | ❑ | ❑ |
| Nursing? | ❑ | ❑ |
| Taking Birth Control | ❑ | ❑ |

## PLEASE CHECK ALL THAT APPLY

- AIDS ❑
- Anemia ❑
- Arthritis/Rheumatism ❑
- Artificial Heart Valves ❑
- Artificial Joints ❑
- Asthma ❑
- Back Problems ❑
- Bleeding Abdominally, with Extractions or Surgery ❑
- Blood Disease ❑
- Cancer ❑
- Chemical Dependency ❑
- Chemotherapy ❑
- Chronic Fatigue Syndrome ❑
- Circulatory Problems ❑
- Congenital Heart Lesions ❑
- Cortisone Treatments ❑
- Cough - persistent or bloody ❑
- Diabetes ❑
- Emphysema ❑
- Epilepsy ❑
- Fainting or Dizziness ❑
- Glaucoma ❑
- Headaches ❑
- Heart Murmur ❑
- Heart Problems ❑
- Hepatitis - Type ___ ❑
- Herpes ❑
- High Blood Pressure ❑
- HIV Positive ❑
- Jaundice ❑
- Jaw Pain ❑
- Latex Sensitivity ❑
- Kidney Disease ❑
- Liver Disease ❑
- Low Blood Pressure ❑
- Mitral Valve Prolapse ❑
- Nervous Problems ❑
- Pacemaker ❑
- Psychiatric Care ❑
- Radiation Treatment ❑
- Respiratory Disease ❑
- Rheumatic Fever ❑
- Scarlet Fever ❑
- Shortness of Breath ❑
- Sinus Trouble ❑
- Skin Rash ❑
- Stroke ❑
- Swelling Feet/Ankles ❑
- Swollen Neck Glands ❑
- Thyroid Problems ❑
- Tonsillitis ❑
- Tuberculosis ❑
- Tumor or Growth on Head/Neck ❑
- Ulcer ❑
- Venereal Disease ❑

Signature of Responsible Party ______________________________ Date ______________

Email Form