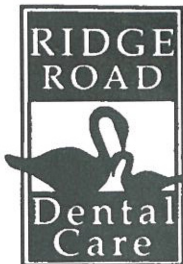

Comfortable Dentistry

18A Ridge Road
Horseheads, New York 14845

607•739•8187

E-mail Address: ____________

Patient Information

Name: (Last) ____________ (First) ____________
Address: ____________
City: ____________ State: ____________ Zip: ____________
Telephone: ____________
Date of birth: ____________ Social Security No.: ____________
Occupation: ____________
Insurance Co.: ____________
Who is responsible for payment? ____________
Place of employment: ____________
Name of physician: ____________ Telephone: ____________
In case of emergency, notify: ____________ Telephone: ____________
How did you hear about Ridge Road Dental Care? ____________
How will you pay for treatment? ____________
Spouses name: ____________
Spouses place of employment: ____________

Health Information

Do You Have Any History of:	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Artificial Joint Replacement	☐	☐
Heart Murmur	☐	☐	Hepatitis	☐	☐
Heart Trouble	☐	☐	Lung Disease	☐	☐
High Blood Pressure	☐	☐	Breathing Problems	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Epilepsy	☐	☐
Any Bleeding Problems	☐	☐	Allergies	☐	☐
Do You Bruise Easily	☐	☐	Fainting or Dizziness	☐	☐
Anemia	☐	☐	Do You Take Medications?	☐	☐
HIV + / Aids	☐	☐	Could You Be Pregnant?	☐	☐
Kidney Disease	☐	☐	Months:	____	
Liver Disease	☐	☐	Venereal Disease	☐	☐

Have you ever experienced or undergone head and neck radiation therapy? ☐ ☐

Have You Had Any Surgery Performed Recently? Yes ☐ No ☐ *When?* ____________
Date of Last Physical: ____________
Date of Last Dental X-ray: ____________ *Age of Dentures:* ____________

List Any Medications You Are Taking:
____
____
____
____

Are You Allergic to Any Medications?
____
____
____
____

Have You Ever Been Given:

	Yes	No
Novocaine	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Codeine	☐	☐

Patient Signature ____________
(Parent's Signature) ____________
Date: ____________
Reviewed by: ____________
Date: ____________

Fee will be added if turned over to collection agency.

Medical Alert

Reason for Today's Visit:

____
____
____