



Ryan W. Comeaux DDS
family dentistry • the woodlands

Patient Information / Initial Registration

The Comeaux Family Dentistry New Patient Form begins on the next page. In order for us to render the proper and optimum dental services for you and to give you the most consideration of your time and feelings, we ask you to please answer completely all of the following questions. Space is provided for any additional information you feel we should be aware of. All responses are of course confidential (if completing a form for someone else – use patient's name and appropriate information for parents or responsible adult).

Thank you for your cooperation.

You may fill in this form and then print it and fax or mail it to us.

Our Fax number is: 832.634.3333

Our mailing address is:

Ryan W. Comeaux DDS

8008 Ashlane Way, Suite 150

The Woodlands, Texas 77382

If you wish to e-mail it to us, please "save as" and give it a new name such as (YOUR NAME) PATIENT FORM.DOC and e-mail it to us as an attachment. The address to use is info@comeauxdds.com.

_____ **Please Initial**

NEW PATIENT INFORMATION

Dr. Mr. Mrs. Miss

Patient Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Age: _____ Male Female Martial Status: _____ Home Phone #: (_____) _____

Cell Ph #: (_____) _____ Spouse's Name: _____

If child: Mothers Name: _____ Fathers Name: _____

Patient Address, Street: _____ City: _____ State: _____ Zip Code: _____

Patient Employer: _____ Position: _____

Employer Address, Street: _____ City: _____ State: _____ Zip Code: _____

Spouse Employer: _____ Position: _____

Employer Address, Street: _____ City: _____ State: _____ Zip Code: _____

If Children will be Treated by Us, Please Provide Their Information:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Nearest Relative Other Than Spouse, Name: _____

Address: _____ Phone #: (_____) _____

ACCOUNT INFORMATION

How do you intend to pay for your Dental Services? _____

Do you have an E-Mail Address, Self: _____ Spouse: _____

Person Financially Responsible for Account:

Last Name: _____ First Name: _____ Middle Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Social Security # _____ Drivers License # _____

Dental Insurance – Primary Carrier, Company Name: _____ Group # _____ Policy # _____

Yes or No – Secondary Carrier, Company Name: _____ Group # _____ Policy # _____

Policy Owner Last Name: _____ First Name: _____ Middle Name: _____

Social Security # _____

Policy Owner Address

Street: _____ City: _____ State: _____ Zip Code: _____

Phone #: (_____) _____

Employer: _____ Insurance Eligibility Date: _____

Employer Address

Street: _____ City: _____ State: _____ Zip Code: _____

Phone #: (_____) _____

Who may we thank for referring you to our office? _____

When was your last dental visit? _____

Please describe your immediate dental needs: _____

Please describe your long-term dental goals: _____

How do you feel about the appearance of your teeth: _____ Shade: _____

Comfort: _____

Please share with us your fears and concerns:

Pain: _____ Expense: _____ Time: _____

Losing your teeth: _____

Other: _____

_____ Please Initial

