BRIGHT SMILES DENTAL

PATIENT INFORMATION

Name_____ Birthdate _____-_____-_____ ☐Male ☐ Female

First MI Last

SSN#_____ Email _____ ☐Married ☐Single ☐Child ☐Other

Home Phone_____ Work Phone_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

Spouse's Name _____ Birthdate _____-_____-_____ Phone _____

Referred by: Yellow Pages Insurance Internet Other: _____

EMERGENCY CONTACT (If 18 and older) /RESPONSIBLE PARTY INFORMATION (patients under 18 years)

Name_____ Birthdate _____-_____-_____ ☐ Male ☐ Female

First MI Last

SSN#_____ Email_____ Relation to Patient: _____

Home Phone_____ Work Phone_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

EMPLOYMENT INFORMATION

The following employment information is for: ☐ For Patient ☐ For Responsible Party

Employer Name: _____ Occupation_____

Address_____City_____State_____Zip Code_____

***DENTAL* INSURANCE INFORMATION**

Primary Insurance Company_____ Ins. Company Phone_____

ID#_____ Insurance Group#_____ Union/Local#_____

Name of Insured_____ Birthdate_____-_____-_____

Do you have any additional insurance? Yes☐ No☐ If Yes, complete the following:

Secondary Insurance Company_____ Ins. Company Phone_____

ID#_____ Insurance Group#_____ Union/Local#_____

Name of Insured_____ Birthdate_____-_____-_____

PATIENT MEDICAL HISTORY

Physician _____Office Phone_____ Date of last exam_____

MEDICATIONS

Please list any medications you are taking

No Medications ☐

_____

_____

_____

Are you taking blood thinners? YES ☐ **NO** ☐

ALLERGIES

Are you allergic to any of the following: Please circle if yes.

Penicillin Latex Aspirin Codeine Local Anesthetics

None

List any other allergies:

_____

_____

Check if you have/ had any of the following:

Y	N	AIDS or HIV Infection	Y	N	Glaucoma	Y	N	Nervous Disorder
Y	N	Anemia	Y	N	Hay Fever/ Allergies	Y	N	Radiation Therapy
Y	N	Angina/Chest pains	Y	N	Heart Murmur	Y	N	Respiratory Problems
Y	N	Arthritis	Y	N	Hepatitis	Y	N	Rheumatic Fever
Y	N	Asthma	Y	N	Heart Attack	Y	N	Stomach Troubles/ Ulcers
Y	N	Cancer	Y	N	Heart Disease	Y	N	Stroke
Y	N	Cardiac Pacemaker/Stents	Y	N	High Blood Pressure	Y	N	Swollen Ankles
Y	N	Diabetes:	Y	N	Low Blood Pressure	Y	N	Thyroid Problem
		Insulin Dependent: **Y N**	Y	N	Jaundice	**Other** _____		
Y	N	Easily Winded	Y	N	Joint Replacement or Implant			
Y	N	Epilepsy/Seizures	Y	N	Kidney Diseases	*Women only:*		
Y	N	Fainting	Y	N	Leukemia	Y	N	Pregnant Due Date_____
			Y	N	Liver Disease	Y	N	Nursing

Do you use tobacco products? If yes, how much & what form _____

Have you been hospitalized, had a major illness, operation or injury in the last 5 years? If yes, please describe

_____

PATIENT DENTAL HISTORY

For new patients: Last Dental Visit _____

Please check if you have any of the following:

- ☐ Gums bleed while brushing or flossing
- ☐ Teeth sensitive to hot or cold liquids/foods
- ☐ Teeth sensitive to sweet or sour liquids/ foods
- ☐ Tooth pain
- ☐ Sores or lumps in or near your mouth
- ☐ Difficulty opening or closing your jaw
- ☐ Pain in your jaw joint, ear or side of the face
- ☐ Have you had any head, neck or jaw injuries?
- ☐ Have you ever had treatment for TMJ?
- ☐ Nail biting, thumb sucking, or mouth breathing
- ☐ Frequent headaches
- ☐ Clench or grind your teeth
- ☐ Bite your lips or cheeks frequently
- ☐ Difficulties with extractions
- ☐ Previous Orthodontic work
- ☐ Prolonged bleeding following extractions
- ☐ Difficult chewing
- ☐ Have had instruction on the correct method of brushing your teeth or the care of your gums?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature (patient, parent or guardian) _____ Date_____