Welcome To Bright Dental

Patient Name: _____ Date of birth: _____

_____

Home Address: _____ City:_____ Postal:_____

Home #:_____Cell #:_____ Work#:_____

Emergency Contact: _____ Phone: _____

How did you hear about Bright Dental? _____

Do you have dental insurance? YES NO

Primary Insurance

Policy Holder: _____

Date of birth:_____

Insurance Company:_____

Employer:_____

Group/Plan: _____

ID:_____

Secondary Insurance

Policy Holder:_____

Date of birth:_____

Insurance Company:_____

Employer:_____

Group/Plan:_____

ID:_____

Please sign and date the below information

Insurance: Total fees are due at the time of service and are the responsibility of the patient/guardian. We will prepare the appropriate paperwork to help you collect from your dental benefits company. If we bill them directly on your behalf you most provide a valid credit card for any balances after insurance has paid their portion. Our fees are based on the current year and may or may not coincide with the fee guide your insurance has chosen to use.

Signature:_____ Date:_____

Privacy Act: We are committed to protecting the privacy of our patients and may use your personal information to open/update our records, share with 3rd part specialists (if we refer), for collection of fees, use of intraoral and radiographs for educational purposes. Your personal information will be utilized in the utmost professional and responsible manner.

Signature:_____ Date:_____

Cancelation Policy: We value and respect your time and expect and same courtesy. We as you provide 48 hour notice prior to your appointment time. A $50 fee will applied to your file if not handled in this fashion.

Signature: _____ Date: _____

Medical History

Name of physician: _____ Date of last medical exam:_____

Do you have any of the following allergies?

Aspirin Clindamycin Tetracycline Seasonal allergies

Codeine Sulfa Drugs Latex Penicillin

Iodine Dental Anesthetics Metals Erythromycin

Sedatives Food Allergies:_____ Other:_____

Are you presently taking any medications(including aspirin, Tylenol, birth control ect…)

Medications Dosage Reason for use

1._____ _____ _____

2. _____ _____ _____

3. _____ _____ _____

Others (vitamins, herbs, minerals, street drugs):_____

Do you have a history of chemical/alcohol dependency? YES NO

If YES please describe: _____

Have you been informed by your physician that you require antibiotics prior to dental treatment? YES NO

Do you smoke? YES NO If YES how many years? _____ How many per day? _____

Do you use chewing tobacco products? YES NO

Do you presently have or have you ever been diagnosed with any of the following:

Anemia Asthma Diabetes Bulimia Autoimmune disorder Acid Reflux

Glaucoma Sleep Apnea Crones/colitis Headaches Hepatitis A/B/C Stroke

Epilepsy Keloid scares Heart murmur Seizures Hemophilia HIV/AIDS Shingles

Multiple Sclerosis Melanoma Port Wine Stain Sinus Problems Tuberculosis

Thyroid problems Stomach Ulcers Local anesthetic sensitivity Arthritis Pacemaker

Emphysema Joint replacement Heart Disease Sleep Apnea Heart Attack Kidney Disease

Women only: Are you currently pregnant? YES NO Are you currently breastfeeding? YES NO

Dental History

Have you had regular dental visits in the past? YES NO

Date of Last Visit? _____

Where X-rays taken? YES NO If YES at which office? _____

How often do you brush? _____ How often do you floss? _____

Do your gums bleed when you brush, floss or use toothpicks? YES NO

Have you had unusual reactions to fluoride? YES NO

If YES, what happened?_____

Do you have any current concerns about your teeth? YES NO

If YES, please describe: _____

Are you nervous/anxious about receiving dental work? YES NO

Are you happy with the appearance and color of your teeth? YES NO

Have you been told you have periodontal/gum disease? YES NO

Are your gums pulling away or receding from your teeth? YES NO

Do you see pus between your teeth/gums when you press on them? YES NO

Do you often get dry mouth? YES NO

Do you have your wisdom teeth? YES NO

If you have lost teeth what was the cause? _____

Do you wear a partial denture? YES NO If YES, are you happy with the fit? YES NO

Do you have areas that are sensitive to biting, chewing, or temperature? YES NO

In your opinion, what would improve your smile to a 10?_____

TMJ Screening

Do you have any facial pain or pressure and where? _____

Do your ears buzz, ring or hiss? YES NO

Do you snore? YES NO

Have you ever been in a motor vehicle accident? YES NO

If YES, when?_____

Do you have a history of trauma to the head, neck, jaw, face, or mouth? YES NO

If YES, please specify: _____

Have you worn braces or dental appliances to straighten your teeth? YES NO

Do you ever have difficulty opening your mouth? YES NO

Do you hear popping, clicking, or grinding noises when you open/close? YES NO

Does your jaw get “locked” or “stuck” or “go out of place”? YES NO

Does your bite feel different, unstable, or uncomfortable? YES NO

Do your jaw problems affect your ability to chew? YES NO

Are you aware if you clench or grind your teeth during the day or night? YES NO

Do you have a night guard to prevent grinding? YES NO If YES, how old is it?_____

Have you previously sought treatment for TMJ disorder? YES NO

Where?_____By Which Doctor?_____

What was done?_____

Cosmetic Evaluation

Have you had Botox or Derma Fillers in the past ?__YES NO_____

What products are you currently using on your skin?_____

Do you have any particular skin sensitivity?_____

Thank you for taking the time to complete this paperwork!