Please complete this form and email to info@brightdental.ca

Dr. Frank Neves & Associates

Welcome to Bright Dental

Patient Name: _____ Date of Birth: _____

Home Address: _____ City: _____ Postal Code: _____

Phone: Home # _____ Mobile # _____ Work # _____ Email: _____

Emergency Contact: _____ Phone Number: _____

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 must 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 third-party specialists (if we refer), for collection of fees, use of intra-oral and radiographs for educational purposes. Your personal information will be utilized in the utmost professional and responsible manner.

Signature: _____ Date: _____

Cancellation Policy: We value and respect your time and expect the same courtesy. We ask you provide 48-hour notice prior to your appointment time. A $50 fee will be 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 currently taking any medications? (including aspirin, Tylenol, birth control, blood thinner/ASA 81mg etc.)

Medication	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 use electronic cigarettes (vaping)?	YES	NO
Do you use marijuana?	YES	NO

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

Anemia	Asthma	Diabetes	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	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? _____

Were X-Rays Taken? YES NO
If YES, at which dental 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? YES NO

If YES, please describe: _____

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 your mouth? 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 completing this paperwork!