BRITE DENTAL
GENERAL AND FAMILY DENTAL CARE

Patient Information

Patient Name: ____ Date of Birth: _____ /______ /______

Address: ____

Email: __________________________________@_____________Cell: (____) _____-_______ Home: (____) _____-_______

Person to contact in an emergency: ____ Contact Number: (____) _____-_______

Address: ____

PRIMARY INSURANCE:

Name of Insured Person on the Account: _______________________________________ Date Of Birth: ______/______/______

Member ID# or SSN: ________________________ Group #: ____________________________________

Name of Employer & Occupation: ____

Relationship of the insured to the patient: __________________ Name & Phone # Of Insurance Company:_________________

SECONDARY INSURANCE:

Name of Insured Person on the Account: _______________________________________ Date Of Birth: ______/______/______

Member ID# or SSN: ________________________ Group #: ____________________________________

Name of Employer & Occupation: ____

Relationship of the insured to the patient: __________________ Name & Phone # Of Insurance Company:_________________

Whom may we thank for referring you to our office? ____

Dental Health History

Are you apprehensive about dental treatments?	Y	N	How often do you brush?	Y	N
Have you had problems with previous dental treatments?	Y	N	How often do you floss?	Y	N
Do you gag easily?	Y	N	Do you prefer to save your teeth?	Y	N
Do you wear dentures?	Y	N	Do you want to complete dental care?	Y	N
Does food catch between your teeth?	Y	N	Does your jaw make noise so that it bothers you or others?	Y	N
Do you have difficulty chewing your food?	Y	N	Do you clench or grind your jaws frequently?	Y	N
Do you chew only on one side of your mouth?	Y	N	Do you have pain in your face, cheeks, jaws, joints, throat, or temples?	Y	N
Do you avoid brushing any part of your mouth because of pain?	Y	N	Do your jaws ever feel tired?	Y	N
Do your gums bleed easily?	Y	N	Do your jaws get stuck?	Y	N
Do your gums bleed when you floss?	Y	N	Do you have earaches or pain in front of the ears?	Y	N
Do your gums feel swollen or tender?	Y	N	Do you have any jaw symptoms or headaches upon awaking in the morning?	Y	N
Have you ever noticed slow-healing sores in or about your mouth?	Y	N	Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	Y	N
Are your teeth sensitive?	Y	N	Do you find jaw pain or discomfort extremely frustrating or depressing?	Y	N
Do you feel twinges of pain when your teeth come in contact with:	Y	N	Do you take medicines or pills for pain or discomfort?	Y	N
• Hot foods or liquids?	Y	N	Do you have a temporomandibular disorder (TMD)?	Y	N
• Cold foods or liquids?	Y	N	Does it hurt when you chew or open wide to bite?	Y	N
• Sours?	Y	N	Are you unable to open your mouth as far as you want?	Y	N
• Sweets?	Y	N	Are you aware of an uncomfortable bite?	Y	N
Do you take fluoride supplements?	Y	N	Have you had a blow to the jaw (trauma)?	Y	N
Are you dissatisfied with the appearance of your teeth?	Y	N	Are you a habitual gum chewer or pipe smoker?	Y	N

Medical History

Do you have any of the following?

Condition		
Heart Problems	Y	N
• Chest pain	Y	N
• Shortness of breath	Y	N
• Blood pressure problems	Y	N
• Heart murmur	Y	N
• Heart valve problem	Y	N
• Taking heart medication	Y	N
• Rheumatic fever	Y	N
• Pacemaker	Y	N
• Artificial heart valve	Y	N
Blood Problems	Y	N
• Easy bruising	Y	N
• Frequent nosebleeds	Y	N
• Abnormal bleeding	Y	N
• Blood disease (anemia)	Y	N
• Ever required a blood transfusion?	Y	N
Allergy Problems	Y	N
• Hay fever	Y	N
• Sinus problems	Y	N
• Skin rashes	Y	N
• Taking allergy medication	Y	N
• Asthma	Y	N
Intestinal Problems	Y	N
• Ulcers	Y	N
• Weight gain or loss	Y	N
• Special diet	Y	N
• Constipation/diarrhea	Y	N
• Kidney or bladder problems	Y	N

Condition		
Bone or Joint Problems	Y	N
• Arthritis	Y	N
• Back or neck pain	Y	N
• Joint replacement	Y	N
Diabetes	Y	N
• Urinate more than 6 times a day	Y	N
• Thirsty or mouth is dry often	Y	N
• Family history of diabetes	Y	N
Fainting Spells	Y	N
Stroke(s)	Y	N
Frequent or severe headaches	Y	N
Thyroid problems	Y	N
Persistent cough or swollen glands	Y	N
Premedications required by physician	Y	N
Cancer/ Tumor	Y	N
Tuberculosis or other respiratory disease	Y	N
Hepatitis, jaundice, or liver trouble	Y	N
Herpes or other STD	Y	N
HIV positive / AIDS	Y	N
Glaucoma	Y	N
Do you wear contact lenses	Y	N
History of head injury	Y	N
Epilepsy, seizures, or other neurological disease?	Y	N
Do you drink alcohol? If so, how often?	Y	N
Do you smoke? If so, how often?	Y	N
Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe________________________	Y	N

Allergies

Allergy		
Local anesthetics (Novocain)	Y	N
Penicillin or other antibiotics	Y	N
Sulfa drugs	Y	N
Barbiturates, sedatives, or sleeping pills	Y	N
Aspirin, acetaminophen, or ibuprofen	Y	N
Codeine, Demerol, or other narcotics	Y	N
Reaction to metals	Y	N
Latex or rubber dam	Y	N
Other	Y	N

Current Medications

Medication		
Antibiotics or sulfa	Y	N
Anticoagulants (eg. Coumadin)	Y	N
High blood pressure medicine	Y	N
Tranquilizers	Y	N
Insulin, Orinase, or similar drug	Y	N
Aspirin	Y	N
Digitalis or drugs for heart	Y	N
Nitroglycerin	Y	N
Coritsone (steroids)	Y	N
Natural remedies	Y	N
Other nonprescription drugs/ supplements	Y	N
Other __________________________________	Y	N

Women Only

Question		
Are you taking contraceptives or other hormones?	Y	N
Are you pregnant?	Y	N
If so, what is expected delivery date?	Y	N

Question		
Are you nursing?	Y	N
Have you reached menopause? If so, symptoms? ___________________________	Y	N

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient / Guardian Signature: ____ **Date:** ______/______/______

If Guardian, Print Name & Relation To Patient:____

Doctor's Notes: ____

Doctors Initials:____________________ **Date:** ______/______/______