Welcome to Bright Smiles

Patient Information

Name:____ Today's Date: ________
first middle last

Social Security Number: _________________ Date of Birth:_______________

Address:_________________ City:_______________ State:____ Zip:_________

Sex: __Male ___Female E Mail: ______________________________

Home Phone:_______________ Cell:_______________ Work:_________________

Where Do you prefer to receive calls? _______________

Patient Employer or School: ________________ Occupation: _________________

Employer's Name: ___________________________

Spouse or Parents Name: ______________________

Whom may we contact in case of an emergency?___________________________

Phone:_________________

Whom may we thank for referring you to us?______________________________

Insurance Information

Name of Insured:______________________ Relationship to Patient:____________________

Birthdate:_____________ Social Security Number:________________

Name of employer:_______________________ Office Phone:_____________________________

Insurance Company:_____________________ Group #:_______ Employer/ID# ____________

Insurance company address:_______________ City/State:_______________ Zip:____________

Do you have Secondary Insurance? ___Yes ___No

Name of Insured:______________________ Relationship to Patient:____________________

Birth date:_____________ Social Security Number:________________

Name of employer:_______________________ Office Phone:_____________________________

Insurance Company:_____________________ Group #:_______ Employer/ID# ____________

Insurance company address:_______________ City/State:_______________ Zip:____________

Medical History: Do you *have* or *had* any of the following......(please circle)

AIDS
Anemia
Arthritis/Rheumatism
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding Abnormalities
Blood Disease
Cancer
Chemical Dependency
Chemotherapy
Circulatory problems
Congenital Heart Lesions
Cortisone Treatments
Diabetes
Epilepsy
Fainting
Glaucoma
Headaches
Heart Murmur
Heart Attack
Heart Problems
Hemophilia
Hepatitis
High Blood Pressure
HIV Positive
Kidney Disease
Liver Disease
Mitral Valve Prolapse
Pacemaker
Psychiatric Care/Problems
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Skin Rash
Sinus Problems
Stroke
Thyroid Problems
Tobacco Habit
Tuberculosis

Are there any other health conditions you have that are not listed?
If so please
explain:____

Women Only:
Are you Pregnant? ___ yes ___ no Nursing? __ yes __no Had an exposure to HPV? __ yes __no

Please List all Allergies:____
Please list all Medications You are taking:
____
____
Who is your Physician? ______________________ Date of Last Physical:_________

Dental History
Date of Last Exam:___________ Reason for Today's Visit:_____________________
Please circle all that apply to your oral health.....

Bad Breath
Bleeding Gums
Clicking popping jaw
Broken Fillings
Grinding/Clenching Teeth
Loose Teeth
Past Periodontal Treatments
Sores/growths in Mouth
Sensitivity to Heat or Cold
Sensitivity to Sweets
Sensitivity when Biting
History of Oral Biopsies

Certification & Assignment
To the best of my knowledge, the above information is complete and correct. I understand that is is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that I, and/or my dependents(s), have insurance coverage with:________________________ and assign Bright Smiles, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient or Legal Guardian:________________________ Date:___________

Print Name of Patient:____________________________________