

PATIENT REGISTRATION

Name: _____
Last First Middle

Birthday: _____ Marital Status: Single / Married / Other
Day Month Year

Mailing Address: _____
Apt/House # Street

City Pr Postal Code

Sex: Male / Female / Prefer not to say Email add: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Health Card no: _____

Occupation: _____ Employer: _____

Emergency Contact Person: _____ Relationship: _____

Contact number: _____

If you are completing this form for another person, what is your relationship to the person?

Your name: _____ Relationship: _____

Who may we thank for referring you to Brightside Dental Studio? _____

DENTAL HISTORY & INFORMATION

What is the reason for your dental visit today? _____

How do you feel about your smile/teeth? _____

Have you had any problems associated with previous dental treatment? _____

Date of your last dental exam: _____

Date of last dental xrays: _____

Name of previous Dentist: _____

Please mark (X) your responses to the following questions that applies:

- Do you wear dentures? (Full or Partial) ()
- Are you unhappy with your dentures? ()
- Are you apprehensive about dental treatment? ()
- Have you had any Periodontal (GUM) treatment? ()
- Do your gums Bleed, or feel tender or irritated? ()
- Are your teeth sensitive to cold, hot, sweets or pressure? ()
- Does food or floss catch between your teeth? ()
- Is your mouth dry? ()
- Have you ever had orthodontic (braces) treatment? ()
- Are you currently experiencing dental pain or discomfort? ()
- Do you have earaches or neck pains? ()
- Do you have any clicking, popping or discomfort in the jaw? ()
- Do you brux or grind you teeth? ()
- Do you have sores or ulcers in your mouth? ()
- Have you ever had serious injury to your head or mouth? ()

MEDICAL HISTORY & INFORMATION

*****Please mark (X) to all that that applies:**

() Are you now under the care of a Physician? _____
Physician Name: _____

() Are you in good health? _____
Date of last physical exam: _____

() Has there been any changes in your general health within the past year?
If yes, what condition is being treated? _____

() Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness or problem? _____

() Are you taking or have you recently taken any prescription or over the counter medicine?
If so, please list all, including vitamins, natural or herbal preparations
and/or diet supplements: _____

() Have you ever used **BISPHOSPHONATE MEDICATION**?
(Brand names *Fosamax, Actonel, Atelvia, Didronel, Boniva, Aclasta*)

() Are you taking or scheduled to begin taking either of the medications for osteoporosis or Paget's disease?

() Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates
for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease,
multiple myeloma or metastatic cancer?
Date treatment began: _____

() Do you use tobacco (smoking, snuff, chew, bidis)?

() Do you drink alcoholic beverages?
If yes, how much alcohol do you typically drink in a week? _____

() **Allergies** - Are you allergic to or have you had a reaction to any of the following;
Specify type of reaction.

- | | |
|--|------------------------|
| () Local anesthetics | () Metals |
| () Aspirin | () Latex (rubber) |
| () Penicillin or other antibiotics | () Iodine |
| () Barbiturates, sedatives, or sleeping pills | () Hay fever/seasonal |
| () Sulfa drugs | () Animals |
| () Codeine or other narcotics | () Food |

Others:

WOMEN ONLY Are you:

() Pregnant:
Number of weeks _____

() Taking birth control pills or hormonal replacement?

() Nursing?

*****Please mark (X) your response of the following which you have had, or presently have:**

- | | |
|---|--|
| <input type="checkbox"/> Artificial (prosthetic) heart valve | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Previous infective endocarditis | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Congenital Heart Disease (CHD) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Unrepaired, cyanotic CHD | <input type="checkbox"/> Cancer/Chemotherapy/Radiation Therapy |
| <input type="checkbox"/> Repaired (completely) in last 6 months | <input type="checkbox"/> Chest pain upon exertion |
| <input type="checkbox"/> Repaired CHD with residual defects | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Diabetes Type I or II |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Gastrointestinal disease |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> G.E. Reflux/persistent heartburn |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> other congenital heart defects | <input type="checkbox"/> Hepatitis, jaundice or liver disease |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Fainting spells or seizures |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Neurological disorders: |
| <input type="checkbox"/> Rheumatic heart disease | <input type="checkbox"/> If yes, specify : |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental health disorders: |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Specify: |
| <input type="checkbox"/> if yes, date: | <input type="checkbox"/> Recurrent infections: |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Type of infection: |
| <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Persistent swollen glands in neck |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Severe headaches/migraines |
| <input type="checkbox"/> Systemic lupus erythematosus | <input type="checkbox"/> Severe or rapid weight loss |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Bronchitis | |

Do you have any disease, condition or problem not listed above that you think I should know about?
Please explain:

I certify that I have read and understand the above and the information given on this form is accurate.

Signature of Patient/Legal Guardian

Date:

***** We require 24 hours notice for all cancellations.**

***** Failure to provide adequate notice may result in a fee.**

Initials

Dental Insurance

Brightside Dental Studio offers direct billing to insurance companies as a convenience to our patients. Dental insurance is intended to assist you with the payment of your dental care, however, there may be procedures that are not covered. As the insurance policy holder you are responsible to be aware of your coverage. Each plan varies significantly and we cannot keep track of everyone's differing benefits. Please ensure that you are aware of all policy changes, yearly limits, deductibles, recall dates, and reset dates pertaining to your own policy for yourself, as well as any covered family members.

Brightside Dental Studio is not responsible for procedures that are not covered by your insurance, so if you have any concerns regarding this, please inquire with one of our staff members to see if a pre-determination is needed prior to your scheduled appointment.

Signature of Patient/Legal Guardian

Date: