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
- [ ] Aspirin
- [ ] Penicillin or other antibiotics
- [ ] Barbiturates, sedatives, or sleeping pills
- [ ] Sulfa drugs
- [ ] Codeine or other narcotics
- [ ] Metals
- [ ] Latex (rubber)
- [ ] Iodine
- [ ] Hay fever/seasonal
- [ ] Animals
- [ ] 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:

- [ ] Artificial (prosthetic) heart valve
- [ ] Previous infective endocarditis
- [ ] Congenital Heart Disease (CHD)
- [ ] Unrepaired, cyanotic CHD
- [ ] Repaired (completely) in last 6 months
- [ ] Repaired CHD with residual defects

- [ ] Cardiovascular disease
- [ ] Angina
- [ ] Arteriosclerosis
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Low blood pressure
- [ ] High blood pressure
- [ ] other congenital heart defects
- [ ] mitral valve prolapse
- [ ] Pacemaker
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Abnormal bleeding
- [ ] Anemia
- [ ] Blood transfusion
  if yes, date:
- [ ] Hemophilia
- [ ] AIDS or HIV infection
- [ ] Arthritis
- [ ] Autoimmune disease
- [ ] Rheumatoid arthritis
- [ ] Systemic lupus erythematosus
- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Sinus trouble
- [ ] Tuberculosis
- [ ] Cancer/Chemotheraphy/Radiation Therapy
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Diabetes Type I or II
- [ ] Eating disorder
- [ ] Malnutrition
- [ ] Gastrointestinal disease
- [ ] G.E. Reflux/persistent heartburn
- [ ] Ulcers
- [ ] Thyroid problems
- [ ] Stroke
- [ ] Glaucoma
- [ ] Hepatitis, jaundice or liver disease
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] Neurological disorders:
  If yes, specify :
- [ ] Sleep disorder
- [ ] Mental health disorders:
  Specify:
- [ ] Recurrent infections:
  Type of infection:
- [ ] Kidney problems
- [ ] Osteoporosis
- [ ] Persistent swollen glands in neck
- [ ] Severe headaches/migraines
- [ ] Severe or rapid weight loss
- [ ] Sexually transmitted disease

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: