Welcome to Bright Smiles

Patient Information

Name: ______________________________ Today's Date: ________
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? _________
Patients Employer/School:______________Occupation:_____________
Employer's Name: _______________________
Spouse or Parent's Name: _________________
Who may we call in case of an emergency? _____________________
Phone:____________________
Who 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 Number:_______________ Employee ID:__________________

Do You have Secondary Insurance? ____ Yes ____No
Name of Insured:______________ Relationship to Patient:_________
Birthdate:_________ Social Security Number:____________________
Name of Employer:________________ Office Phone:_______________
Insurance Company:_______________
Group Number:__________________ Employee ID:_________________

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

AIDS	Diabetes	Psychiatric Care
Anemia	Epilepsy	Radiation Therapy
Arthritis	Glaucoma	Sinus Problems
Artificial Heart valve(s)	Heart Murmur	Stroke
Asthma	Heart Attack	Steroid Therapy
Back Problems	Hepatitis	Tobacco Habit
Bleeding Abnormalities	High Blood Pressure	Tuberculosis
Blood Disease	HIV Positive	COPD
Cancer	**Joint Replacement**	Pacemaker
Chemical Dependency	Kidney Disease	**Endocarditis**
Chemotherapy	Liver Disease	

Are there any other health conditions that you have that are not listed?____

Medications:____

Allergies: ____

Women Only:

Are you Pregnant? ____Yes __ No Nursing?__Yes __No___

Physicians Name:____________________ Physical Date:____________

Dental History

Date of Last Exam:________ Reason for today's Visit:______________

Please circle all that apply to your oral health.....

Bad Breath	Grinding/Clenching teeth	Hot/Cold Sensitive
Bleeding Gums	Loose Teeth	Sweet Sensitive
Jaw Pain	Past Perio Treatments	Biting Sensitive
Sores or Growths	Broken fillings or teeth	Oral biopsy history

Certification & Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health. I certify that I or my dependents have insurance coverage with ________________________________ and assign Bright Smiles, LLC all insurance benefits. 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 claims.

Signature: ______________________________ Date: __________________