# BRIGHT DENTAL CARE

320 Bristol Street, Suite H Costa Mesa, CA 92626 CHART# _____

DATE: _____

PATIENT NAME: _____ AGE: _____ DOB: _____
LAST FIRST MI MM/DD/YY

## DENTAL HISTORY:

Do you have any present dental complaints? _____ Where? _____
When was your last full-mouth X-ray taken? _____ Where? _____
When was your last cleaning? _____Where? _____
Was there any dental treatment performed? _____ Where? _____
Have you ever had any problems with past dental treatment? _____
Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain, or locking?
No___ Yes (please specify) _____
Do your gums bleed easily? No___ Yes___ Do you feel you have bad breath? No___ Yes___
Are your teeth sensitive to hot or cold? No___ Yes ___
Are there any cosmetic changes you would like to have done on your teeth? No___ Yes (please specify)_____

## MEDICAL HISTORY:

Physician _____ Address_____Phone_____
Are you in good health? Yes___ No (please specify) _____
Have you been hospitalized in the past two years? No___ Yes (please specify) _____
Are you taking any medication, pills or drugs? No___ Yes (please specify) _____
(Women) Are you pregnant at this time? No___ Yes (how many months) _____
Do you bleed excessively when cut? No___ Yes___
Have you ever taken any of the following medications: Fen-Phen or Redux No___ Yes ___
Have you ever taken any Biphosphonates? (Fosamax, Boniva) No___ Yes___

Do you have, or have you had any of the following?

| | | | |
|---|---|---|---|
| Allergy to: Penicillin | Yes__ No__ | Kidney Disease | Yes__ No__ |
| Other Antibiotics | Yes__ No__ | Liver Disease | Yes__ No__ |
| Local Anesthetic | Yes__ No__ | Low Blood Pressure | Yes__ No__ |
| Latex | Yes__ No__ | Lung Disease | Yes__ No__ |
| Codeine | Yes__ No__ | Tumor history | Yes__ No__ |
| Other | Yes__ No__ | Psychiatric Care | Yes__ No__ |
| AIDS/HIV | Yes__ No__ | Rheumatic Fever | Yes__ No__ |
| Arthritis | Yes__ No__ | Sinus Trouble | Yes__ No__ |
| Asthma | Yes__ No__ | Smoking Tobacco | Yes__ No__ |
| Blood Disease | Yes__ No__ | Stroke | Yes__ No__ |
| Cancer | Yes__ No__ | Thyroid Problems | Yes__ No__ |
| Chemo/Rad. Therapy | Yes__ No__ | TMD/TMJ | Yes__ No__ |
| Diabetes | Yes__ No__ | Tuberculosis | Yes__ No__ |
| Drug Addiction | Yes__ No__ | Venereal Disease | Yes__ No__ |
| Epilepsy | Yes__ No__ | Any Major Operations | Yes__ No___ |
| Heart Murmur | Yes__ No__ | | |
| Heart Disease | Yes__ No__ | | |
| Hepatitis | Yes__ No__ | | |
| High Blood Pressure | Yes__ No__ | | |
| Joint Prosthesis | Yes__ No__ | | |

***DOCTOR'S COMMENTS***

_____
_____
_____
_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and or medication. I further certify that I consent to the performing of x-rays and oral examination.
I also agree to assume full financial responsibility for all treatment rendered.
Patient's Signature _____ Date_____
(Parents signature if the patient is a minor)
Doctor's Signature _____

**Recall Review**: (Returning Patients)
Patient's Signature _____ Doctor's Signature _____ Date_____
Patient's Signature _____ Doctor's Signature _____ Date_____
Patient's Signature _____ Doctor's Signature _____ Date_____