

COSMETIC & HOLISTIC DENTISTRY

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WELCOME!

Name:	Birthdate:	Today's Date:		
Address:	Phone:	Cell:		
City	Zip	Work:	E-mail:	
If patient is a minor give name of parent or legal guardian:				
How did you hear about our office?				
Dental Insurance:		Spouse/Emergency contact:		
Subscriber ID/ S.S #	D.O.B	Phone:		
Health History				
Do you have or have you ever had?				
pacemaker	heart valve problem	heart murmur	chest pain	
artificial joints	rheumatic heart disease	artificial heart valve	stroke	
Please check any of the following conditions that you now have or have had.				
Anemia/blood disorder	Blood Transfusion	Lungs (TB, Asthma, Emphysema)		
Diabetes	Heart Disease	Gland Problems (thyroid, pituitary)		
Hepatitis (jaundice)	High Blood Pressure	Epilepsy, convulsions		
AIDS, ARC, HIV Pos.	Liver/kidney Problems	Nerous Breakdown. Psychotherapy		
Allergies	Bleeding/Clotting Problems	Cancer, Tumors, Growths		
Venereal Disease	Arthritis/Rheumatism	X-ray, Radium, or Cobalt Treatments		
Glaucoma	Sinus	Persistent Cough		
Cortisone Therapy	Stomach Ulcers	Alcohol/Drug Addiction		
Tuberculosis	Latex Sensitivity	Cold Sores/Fever Blisters		
Hemophilia	Sickle Cell Disease	Bruise easily		
Please list any conditions not mentioned above:				
Please list any allergies you have:				
Are you pregnant?				
Please list all drugs taken in the past year:				
E.S.S.				
How likely are you to doze off or fall asleep in the following situations?				
	0	1	2	3
Check one in each row:	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (i.e. a theater or a meeting)				
As a passenger in a car for an an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopping for a few minutes in traffic				

Dental History

What is the reason for your dental visit today?

Date of last visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-rays: _____

What was done at your last dental visit?

How often do you brush? _____ How often do you floss? _____

Any bleeding when you brush or floss?

Do you have any dental problems now?

If yes, please describe:

Are any of your teeth sensitive to Hot: yes no

Are any of your teeth sensitive to Cold: yes no

Are any of your teeth sensitive to Sweets: yes no

Have you noticed any mouth odors or bad tastes in your mouth: yes no

Do you frequently get cold sores or blisters: yes no

Do your gums bleed or hurt: yes no

Have your parents experienced gum disease or tooth loss: yes no

Have you noticed any loose teeth or changes in your bite: yes no

Does food tend to become caught in between your teeth: yes no

If so, where:

Do you:

Clench or grind your teeth while awake: yes no

Clench or grind your teeth while asleep: yes no

Bite your cheeks or lips regularly: yes no

Have tired jaws (especially in the am): yes no

Smoke or chew tobacco: yes no

Have you ever had: yes no

Orthodontic (braces) Treatment: yes no

Oral surgery: yes no

Periodontal (gum) Treatment: yes no

Your teeth ground or bite adjusted: yes no

A bite plate or Mouthguard: yes no

Serious injury to your mouth or head: yes no

If yes, please describe:

Have you experienced:

Popping or Clicking of the jaw joint: yes no

Pain in the ear, joint or side of face: yes no

Difficulty opening or closing mouth: yes no

Headaches, Neck Aches or Shoulder Aches: yes no

Sore Muscles (Back, Hips, Joints): yes no

Are you satisfied with the appearance of your teeth: yes no

If not, what would you improve?

On a scale of 1-10 (10=high, 1= low), rate your smile: _____

Do you feel nervous about having dental treatment: yes no

If so, what is your biggest concern: _____

Have you ever had a bad dental experience: yes no

If so, explain:

Med. HX Update

To the best of my knowledge the above information is correct. I agree that Dr. Brightleaf may discuss my condition with my physician and receive medical information from her/him. I give my permission for dental treatment and for photos/x-rays to be taken as necessary. I understand I am financially responsible for all services rendered.

Signature _____

Print Name _____