



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: _____