Bright Smiles Cosmetic & Implant Dentistry
1444 Kempsville Road Suite 101
Virginia Beach, VA 23464
(757) 497-8611

Welcome to the practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION (Confidential)

Name____
Last First Mi

SSN________-_______-_______ DOB__________________________

Check Box ❑ Minor ❑ Single ❑ Married

Address____

City ___________________State ___________Zip code____________

Home Phone ________________Work Phone_____________________
Cell Phone__________________
Email___________________________

Occupation _______________ Name of Employer ________________

Address____

Whom may we thank for referring you? _______________________

RESPONSIBLE PARTY (person responsible for account)

Name____
Last First Mi

Relationship to patient_____________________________________
Home #_____________________Work #______________________

SSN__________-________-_________DOB_____________________

Employer____
Is this person currently a patient in our office? ❑Yes ❑ No

INSURANCE INFORMATION
(Provide same information shown on ins. card)

Name of Employer____

Name of Insured____
DOB_________________________SSN_______-_______-_________

Insured ID#_____________________ Group#___________________
Insurance Company____
Ins. Co. Address____
Ins. Phone #____

DENTAL HISTORY

Date of last dental exam____________________________________
Where? ____
Was treatment recommended? ______________________________
Was treatment completed? ________________________________
If not, Why? ____
Are you pleased with the appearance of you teeth? ❑ Yes ❑ No
What problems have you had with your teeth? ____________________
____
Is there any particular treatment you would like to discuss?
____

HEALTH QUESTIONS (check box if any apply)

- ❑ Heart Murmur
- ❑ Heart Disease
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Artificial Heart Valves
- ❑ Prosthetic Joint Replacement
- ❑ Kidney Disease
- ❑ Respiratory Disease
- ❑ Immunosuppressive Disease
- ❑ Chemotherapy
- ❑ Radiation Therapy
- ❑ Abnormal Bleeding
- ❑ Anticoagulant Therapy
- ❑ History of Cancer
- ❑ Cysts, Growth or Tumor
- ❑ Jaundice or Liver Disease
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Frequent Headaches
- ❑ GI- Ulcer
- ❑ Take daily Aspirin
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ HIV (AIDS)
- ❑ Hepatitis
- ❑ Diabetes
- ❑ Asthma
- ❑ Arthritis
- ❑ Anemia
- ❑ Hemophilia
- ❑ Venereal Disease
- ❑ Chronic Diarrhea
- ❑ Stroke
- ❑ Epilepsy
- ❑ Taken Steroids
- ❑ Glaucoma
- ❑ Rheumatic Fever
- ❑ Psychiatric Care
- ❑ Smoke
- ❑ Blood Disease
- ❑ Tuberculosis
- ❑ Take Birth Control Pills
- ❑ Are you pregnant?
  ❑ YES ❑ NO

Do you have any health problems that need further clarification?
❑ Yes ❑ No
If yes, please explain____________________________________
____

Do you have any allergies to the following?:
❑ Codeine ❑ Penicillin ❑ Aspirin
❑ Local Anesthesia ❑ Sulfa Drugs ❑ Barbiturates
❑ Latex ❑ Other: ________________

Are you currently taking any medication? ❑ Yes ❑ No

If yes, Please list all medication you are taking
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________

Date of last medical exam_______________________________
Physician's Name______________________________________
Phone_________________________

INCASE OF EMERCENCY PLEASE NOTIFY:

Name__________________________Relationship____________

Home Phone________________Work /Cell_________________

Name__________________________Relationship____________

Home Phone________________Work/Cell_________________

____
Signature of patient/guardian if minor

____
Date