BRILLIANT DENTAL
DR. TODD BRILLIANT

How did you find out about us? Our practice grows by referrals from our dental family... who may we thank for referring you to us for your dental care?

_____

personal information

Patient Name: _____ Home Phone: _____ Birth Date: _____

Address: _____ City: _____ Zip Code: _____

Cell Ph: _____ Employer: _____ Wk Phone: _____ E-mail: _____

In case of emergency, whom should we notify?

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

billing information

Person responsible for paying bill: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

dental insurance information

Primary Carrier

Name of Insured: _____

Birthdate: _____ Social Security #: _____

Employer: _____

Name of Insurance Company: _____

Address: _____

Group Number: _____ Patient ID#: _____

Secondary Carrier

Name of Insured: _____

Birthdate: _____ Social Security #: _____

Employer: _____

Name of Insurance Company: _____

Address: _____

Group Number: _____ Patient ID#: _____

dental information

Are you in dental discomfort at this time? Yes ☐ No ☐

What would you like us to do during your first visit to our office?

How long has it been since your last dental treatment?
What was done at that time?

Are you fearful, concerned or nervous about dental treatment?

What would you like us to do to make you more comfortable or relaxed during your dental visits?

Are any of your teeth sensitive to
☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

Do you clench or grind your teeth? Yes ☐ No ☐

Do you snore or have Sleep Apnea? Yes ☐ No ☐

Do you have frequent "tension" headaches? Yes ☐ No ☐

Do you have dry mouth? Yes ☐ No ☐

Do you smoke or use chewing tobacco? Yes ☐ No ☐

Do your gums bleed when you floss or brush? Yes ☐ No ☐

Have you ever been treated by a periodontist (gum specialist)? Yes ☐ No ☐

Have you ever had orthodontic treatment? Yes ☐ No ☐

How do you feel about the appearance of your teeth? _____

_____

_____

What do you want long term for your mouth? _____

_____

_____

Is there anything else you would like us to know about your dental health or your previous dental treatment? _____

_____

_____

_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

I have reviewed a copy of this office's Notice of Privacy Practices.

Date: _____ Initials _____

I acknowledge that I have reviewed a copy of the Dental Materials Fact Sheet issued in 2004.

Date: _____ Initials _____

Copies of both documents are available for review at the reception desk.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____