Thank you for choosing Chandler Bright Family Dentistry

PATIENT INFORMATION

Name:_____
(First) (Middle Initial) (Last)

Date of Birth:_____/_____/_____

Male Female

Single Minor Married Widowed

Separated Divorced Partnered

Address:_____

City:_____State:_____ Zip Code:_____

Social Security Number:_____-_____-_____

Email Address:_____

Employer/School:_____

Occupation:_____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home: (_____)_____-_____

Mobile: (_____)_____-_____

Work: (_____)_____-_____Ext:_____

Best time and place to be reached:_____

Spouse's Name:_____

Spouse's Phone: (_____)_____-_____

IN CASE OF EMERGENCY CONTACT

(Please specify someone who does NOT live in your household.)

Name:_____

Relationship:_____

Phone #: (_____)_____-_____

INSURANCE INFORMATION

Ins Company:_____
Member/Policy ID # (Can be the subscribers SSN):

_____
Subscriber/Policy Holder Name:

_____
(First) (Middle Initial) (Last)

D.O.B.:_____/_____/_____Employer:_____

***Is the PATIENT covered by secondary insurance*?** YES NO
(if yes please fill out the section below for the secondary insurance.)

Ins Company:_____
Member/Policy ID # (Can be the subscribers SSN):

_____
Subscriber/Policy Holder Name:

_____
(First) (Middle Initial) (Last)

D.O.B.:_____/_____/_____Employer:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to the doctors at Chandler Bright Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. 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 submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies)and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____

(PRINTED Name of Patient, Parent, Guardian or Personal Representative)

Relationship to patient:_____

X_____

(Signature of Patient, Parent, Guardian or Personal Representative)

Date:_____/_____/_____

DENTAL HISTORY

Reason for today's visit:_____ How often do you floss:_____

Date of last dental visit:_____ How often do you brush:_____

HEALTH HISTORY

Primary Care Physician's Name:_____Cardiologist (If applicable) _____

Primary Care Physician's Phone:_____Cardiologist's Phone:_____

Please *CIRCLE* "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease (COPD)	Yes	No
Alcoholism	Yes	No	Fainting or dizziness	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Seizure	Yes	No
Arthritis, Rheumatism	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Heart Attack, Year _____	Yes	No	Shortness of Breath	Yes	No
Artificial Knee Joints, Side _____	Yes	No	Heart Disease, Name _____	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis, Type _____	Yes	No	Smoking	Yes	No
Bleeding abnormally, with			Herpes (Cold Sores)	Yes	No	Special Diet	Yes	No
extractions or surgery	Yes	No	High Blood Pressure	Yes	No	"Fen-Phen" Diet	Yes	No
Blood Disease, Name _____	Yes	No	Jaundice	Yes	No	Stent	Yes	No
Blood Thinners, Name _____	Yes	No	Jaw Pain	Yes	No	Stroke, Year _____	Yes	No
Cancer, Type _____	Yes	No	Kidney Disease	Yes	No	Swollen Feet or Ankles	Yes	No
CBD	Yes	No	Liver Disease	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency/Addiction	Yes	No	Low Blood Pressure	Yes	No	Thyroid Problems, Hypo or Hyper	Yes	No
Chemotherapy	Yes	No	Marijuana, Medical or Recreational	Yes	No	Tonsillitis	Yes	No
Chewing Tobacco	Yes	No	Mitral Valve Prolapse	Yes	No	Total Hip Replacement, Side _____	Yes	No
Circulatory Problems	Yes	No	Nervous Problems	Yes	No	Tuberculosis	Yes	No
Congenital Heart Defects	Yes	No	Osteoporosis	Yes	No	Tumor or growth on head or neck	Yes	No
Cortisone Treatments	Yes	No	IV infusion (Osteoporosis)	Yes	No	Ulcer	Yes	No
Cough, Persistent or bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes, Type _____	Yes	No	Pre-Med prior to dental treatment	Yes	No	Weight Loss, Unexplained	Yes	No
Depression	Yes	No	Psychiatric Condition	Yes	No	Others: _____		
Emphysema	Yes	No	Radiation Treatment	Yes	No			

WOMEN ONLY:

Are you pregnant? Yes No How many weeks?_____ Are you nursing? Yes No Taking Birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name:_____

Phone or Crossroads: _____

ALLERGIES

Aspirin

Amoxicillin

Barbiturates (Sleeping Pills)

Codeine

Iodine

Others_____

Latex

Local Anesthetics

Penicillin

Sulfa

Vicodin

Patient or (Guardian) Signature: ***Date:*** ***Dentist's Signature:*** ***Date:***