



ORTHODONTICS EXCLUSIVELY
Dr. Bright, DDS, MS & Team

David S. Bright DDS, MS

ORTHODONTICS
EXCLUSIVELY

Patient Information

Date _____ Email Address _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ How long at this address _____
Street City

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

DENTAL HISTORY:

Dentist _____ Telephone # _____

Date of Last Visit _____

If I had a magic wand, and if I could change anything about your smile, what would you want me to change? _____

Yes No Are you presently in any dental pain? If yes, in what location _____

Yes No Have you ever experienced any unfavorable reaction to dentistry?

Yes No Have you ever lost or chipped any teeth? If yes, which tooth? _____

Yes No Have there been any injuries to face, mouth or teeth? If yes, where _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do you have any type of thumb or tongue habit: _____

Yes No Are you a mouth breather?

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Do you have any concerns on receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment with our office? _____

Who? _____

How did they feel about the result? _____

Have you had any history of TMJ or TMJ procedures in the past, if yes, please explain:

Are you experiencing any discomfort in the jaw joint? If so, please explain:

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

Yes No Do you have "tension" headaches?

Yes No Are you pregnant? Due to body growth and jaw growth has menstruation started? If yes, what month and year _____.

If the patient is under age 16, height of parents? Mom _____ Dad _____

Yes No Are you aware that some appointments will be during school/work hours?

We like to know you better, please list some hobbies, interests or pets _____

Do you play a musical instrument? If yes, what? _____

What do you like doing in your spare time? _____

Yes No Do your gums bleed when brushing? # of times per week you floss _____ # of times per day you brush: _____ Type of bristle used: Hard ___ Medium ___ Soft _____

MEDICAL HISTORY

Patient's Name _____ Nickname _____

School Patient attends _____

Physician _____ Date of Last Visit _____

Please circle Yes or No (If yes, please fill in details)

Yes No Are you in good health? _____

Yes No Are you allergic to any medication? If so, what? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Do you need to be medicated for dental procedures? If so, name of medication _____

Abnormal bleeding	Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes		Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure		Radiation/Chemotherapy
Asthma or Hay Fever	Gastrointestinal Disorders	HIV/Aids		Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems		Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders		Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

What medications are you taking? _____

BENEFITS

Benefits of orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph.

Signature _____ Date: _____

I have truthfully answered all the above questions and agree to inform this office of any changed in my medical or dental history. In addition, I authorize Dr. David S. Bright to perform a complete orthodontic evaluation.

Signature _____ Date: _____