BRILLIANT
DENTISTRY

Patient Name _____ Date of Birth_____

Address_____ City/State/ZIP_____

Employer_____ Work Phone # _____

Home Phone # _____ Cell Phone # _____

Email _____ SSN _____

Marital Status_____ Spouse Name & DOB _____

Emergency Contact_____ Contact Phone #_____

Place a mark on "yes" or "no" to

AIDS/HIV	❑Yes	❑No	Fainting or dizziness	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Anemia	❑Yes	❑No	Glaucoma	❑Yes	❑No	Tumor or growth on		
Arthritis, Rheumatism	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Head/Neck	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	Heart Problems	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Headaches	❑Yes	❑No
Asthma	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Bleeding abnormally,	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Jaw Popping	❑Yes	❑No
with extractions or surgery			Liver Disease	❑Yes	❑No	Limited Opening	❑Yes	❑No
Blood Disease	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Congested Ears	❑Yes	❑No
Cancer	❑Yes	❑No	Heart Attack	❑Yes	❑No	Dizziness	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Pacemaker	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Posture Problems	❑Yes	❑No
Heart Lesions	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Clenching	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Stroke	❑Yes	❑No	Grinding	❑Yes	❑No
Persistent cough	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Facial Pain	❑Yes	❑No
Diabetes	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Neck Ache	❑Yes	❑No
Epilepsy	❑Yes	❑No	Thyroid Problems	❑Yes	❑No	Bell's palsy	❑Yes	❑No

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

_____

_____

_____

Are you allergic to any medications or other substances?

_____

Have you received or currently receiving medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

❑Yes ❑No List Medication _____

Please list any major surgeries_____

_____

_____

Circle if: you have seen an Orthodontist, had your bite adjusted, had any bite related treatment or TMJ Joint Surgery?

Circle if: you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor, or Massage Therapist.

Circle if: you snore, use a CPAP or have had a sleep study?

Have you ever had radiation treatment to the head and/or neck? ❑Yes ❑No

Do you use tobacco products? ❑Yes ❑No

Are you pregnant or nursing? ❑Yes ❑No

Do you take a premed antibiotic for dental appointments?

❑Yes ❑No List Medication_____

Signature: _____ **Date:** _____