Welcome to Bright View Dental Care

Patient Profile

First Name: ____________ Last Name: ____________ Preferred Name: ____________
Address: ____________ City: ________ Province: ________ Postal Code: ________
Home #: ____________ Cell #: ____________ Work #: ____________
Email: ____________ Preferred method of contact: ○ Phone / ○ Email / ○ Text
Date of Birth: ____________ Age: ____________ Gender: ____________
Partner Name and Contact: ____________ Physician: ____________
Occupation: ____________ Employer: ____________
How did you hear about us ____________

Insurance Information

Primary Insurance: ____________
Name of Policy Holder: ____________ Policy Holder Date of Birth: ____________
Insurance Company: ____________ Policy/Group #: ____________ ID/Certificate #: ____________

Secondary Insurance: ____________
Name of Policy Holder: ____________ Policy Holder Date of Birth: ____________
Insurance Company ____________ Policy/Group #: ____________ ID/Certificate #: ____________

Do you have any of the following?

Tooth Aches		Bleeding gums	
Sensitivity to hot/cold		Loose teeth	
Food collection between teeth		Bad breath/taste	
Sensitivity during dental cleaning		Grinding/clenching	

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain? ○ Yes ○ No ○ Not Sure/Maybe
2. Do you have, or have you ever had asthma? ○ Yes ○ No ○ Not Sure/Maybe
3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them
4. Do you have any allergies? If yes, please list them:

Aspirin		Sulfa		Peanut/nuts	
Penicillin		Seasonal		Diary/Other	
Codeine		Metal		Rubber/Latex	

5. Do you have, or have you ever had any heart or blood pressure problems?
   ○ Yes ○ No ○ Not Sure/Maybe

6. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart a heart condition from birth or a heart transplant? ○ Yes ○ No ○ Not Sure/Maybe

7. Do you have a prosthetic or artificial joint? ○ Yes ○ No ○ Not Sure/Maybe

8. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ○ Yes ○ No ○ Not Sure/Maybe

9. Have you ever had hepatitis, jaundice or liver disease? ○ Yes ○ No ○ Not Sure/Maybe

10. Do you have a bleeding problem or bleeding disorder? ○ Yes ○ No ○ Not Sure/Maybe

11. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
    ○ Yes ○ No ○ Not Sure/Maybe

____

12. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
    ○ Yes ○ No ○ Not Sure/Maybe

____

13. Do you smoke or chew tobacco products? ○ Yes ○ No ○ Not Sure/Maybe

14. Are you nervous during dental treatment? ○ Yes ○ No ○ Not Sure/Maybe

15. **For women only**. Are you breastfeeding or pregnant? ○ Yes ○ No ○ Not Sure/Maybe

16. Do you identify as a patient with a disability? If yes, please explain
    ○ Yes ○ No ○ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: ------------------------------------Date:----------------------

Dentist Signature:--- Date:----------------------