SUNBRITE DENTAL

PATIENT'S DENTAL HEALTH

I consider my health to be (check one): ❒ Excellent ❒ Good ❒ Fair ❒ Poor

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

1. ❒Y ❒N Heart Disease
2. ❒Y ❒N Heart Murmur/Mitral Valve Prolapse
3. ❒Y ❒N Stroke
4. ❒Y ❒N Congenital Heart Lesions
5. ❒Y ❒N Rheumatic Fever
6. ❒Y ❒N Pacemaker
7. ❒Y ❒N Stent
8. ❒Y ❒N Abnormal Blood Pressure
9. ❒Y ❒N Anemia
10. ❒Y ❒N Prolonged Bleeding Disorder
11. ❒Y ❒N Tuberculosis or Lung Disease
12. ❒Y ❒N Asthma
13. ❒Y ❒N Hay Fever
14. ❒Y ❒N Sinus Trouble
23. ❒Y ❒N Epilepsy/Seizures
24. ❒Y ❒N Ulcers
25. ❒Y ❒N Liver Disease
26. ❒Y ❒N Jaundice
27. ❒Y ❒N Hepatitis Type ____________
28. ❒Y ❒N Diabetes
29. ❒Y ❒N Excessive Urination and/or Thirst
30. ❒Y ❒N Infectious Mononucleosis ("Mono")
31. ❒Y ❒N Herpes
32. ❒Y ❒N Arthritis
33. ❒Y ❒N Sexually Transmitted/Venereal Diseases
34. ❒Y ❒N Kidney Disease
35. ❒Y ❒N Tumor or Malignancy
36. ❒Y ❒N Cancer/Chemotherapy
37. ❒Y ❒N Radiation/Therapy
38. ❒Y ❒N History of Drug Addiction
39. ❒Y ❒N HIV
40. ❒Y ❒N AIDS
41. ❒Y ❒N Immune Suppressed Disorder
42. ❒Y ❒N Hearing Loss
43. ❒Y ❒N Fainting Spells
44. ❒Y ❒N Glaucoma
45. ❒Y ❒N History of Emotional or Nervous Disorders

WOMEN:

46. ❒Y ❒N Are you taking birth control medication?
47. ❒Y ❒N Are you or could you be pregnant or nursing?

15. ❒Y ❒N Implants/Artificial Joints: ______________ Hip-Knee ____________ Other ____________
16. ❒Y ❒N I smoke or use chewing tobacco. If yes, how much per day? ____________ How many years? ______
17. ❒Y ❒N I have consumed alcohol within the last 24 hours.
18. ❒Y ❒N I usually take an antibiotic prior to dental treatment.
19. ❒Y ❒N Have you ever taken Fen-Phen or Redux?
20. ❒Y ❒N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
21. ❒Y ❒N I have had major surgery. Year ________ Type of operation __________ Year ________ Type of operation ____________
22. ❒Y ❒N Do you have any other medical problem or medical history NOT listed on this form? ______________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

48. ❒Y ❒N Aspirin
49. ❒Y ❒N Ibuprofen
50. ❒Y ❒N Sulfa Drugs/Sulfites/Sulfides
51. ❒Y ❒N Penicillin
52. ❒Y ❒N Codeine
53. ❒Y ❒N Latex, Metals, Plastics
54. ❒Y ❒N Local Anesthetics (i.e., Novocain, Lidocaine
55. ❒Y ❒N Other Medications Which ones?

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medicine	Condition
Medicine	Condition
Medicine	Condition
Medicine	Condition
Physician's Name	Phone
Address	Fax

RESPONSIBLE PARTY

Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Birthdate
Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Separated	Relationship to Patient	Drivers License and State

DENTAL INSURANCE INFORMATION

Insurance Co. Name	Phone	Group/Policy No.
Insured's Name	Insured's Birthdate	Relation
Insured's SSN	Insured's Employer	
Secondary Insurance Co. Name	Phone	Group/Policy No.
Insured's Name	Insured's Birthdate	Relation
Insured's SSN	Insured's Employer	

EMERGENCY CONTACTS

Name	Relationship	Phone
Name	Relationship	Phone