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BRSH

Cosmetic & Comprehensive Dentistry

HEALTH HISTORY FORM

NAME (LAST, FIRST, MIDDLE) | NICKNAME | DOB / / | SEX M F | MARITAL STATUS S M D W | SS#

HOME ADDRESS | CITY | STATE | ZIP

NAME OF EMPLOYER | OCCUPATION | NAME OF SCHOOL | GRADE

BUSINESS ADDRESS | CITY | STATE | ZIP

HOME# | WORK# | CELL# | E–MAIL:

DENTAL INSURANCE COMPANY | If coverage is provided by another family member: NAME (LAST, FIRST, MIDDLE) | SPOUSE/PARENT RELATIONSHIP TO YOU | EMPLOYER

In case of an emergency call: (close relative) | HOME ADDRESS | HOME PHONE#

BUSINESS ADDRESS | BUSINESS PHONE#

EXCELLENT/GOOD/FAIR/POOR
GENERAL HEALTH | NAME OF CURRENT PHYSICIAN | ADDRESS | PHONE#

ARE YOU PREGNANT? YES/NO
DO YOU SMOKE? YES/NO
ARE YOU ALLERGIC TO ANY MEDICATIONS? YES/NO
ARE YOU TAKING ANY MEDICATION NOW? YES/NO

IF YES, WHEN IS THE EXPECTED DELIVERY DATE? _____
IF YES, HOW MUCH? _____
IF YES, WHICH MEDICATION(S)? _____
IF YES, PLEASE LIST : _____

MEDICATION(S)

PLEASE CIRCLE ANY OF THE CONDITIONS YOU HAVE HAD:

HEART DISEASE	STENTS	MITRAL VALVE PROLAPSE	CHEMOTHERAPY/RADIATION
RHEUMATIC FEVER	ARTHRITIS	NIGHT SWEATS	GLAUCOMA
ABNORMAL BLOOD PRESSURE	ARTIFICIAL JOINTS, RODS, OR PINS	HEART MURMUR	PERSISTENT DIARRHEA
ULCERS	STD(S)	JAUNDICE	STROKE
TUBERCULOSIS OR LUNG DISEASE	AIDS	DRASTIC WEIGHT LOSS	SWOLLEN ANKLES
DIABETES	PROLONGED BLEEDING	ASTHMA OR HAY FEVER	
EPILEPSY	DRY MOUTH	SINUS TROUBLE	
ANEMIA	CANCER	HEPATITIS	

IF YOU ANSWERED YES TO ANY OF THE PREVIOUS CONDITIONS , PLEASE EXPLAIN: _____

PREVIOUS SURGERIES _____
HOW DID YOU HEAR ABOUT US? _____

PATIENT SIGNATURE _____ DATE _____

Please continue to the next page...

DENTAL HEALTH AND APPEARANCE

REASON FOR VISIT?_____ DATE OF LAST DENTAL VISIT?_____

WHAT IS YOUR PRIMARY CONCERN THAT YOU WOULD LIKE US TO ADDRESS FIRST?_____

WHEN WOULD YOU LIKE TO START TREATMENT? _____

HAVE YOU EVER HAD ANY SERIOUS PROBLEM(S) ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES/NO

IF YES, PLEASE EXPLAIN:_____

WHAT, IF ANYTHING, HAS HAPPENED AT PREVIOUS DENTAL EXPERIENCES, THAT CAUSED YOU NOT TO RETURN? _____

DO YOU HAVE ANY MISSING TEETH? YES/NO IF YES, HOW MANY? _____

IF YOU'VE HAD TEETH REPLACED, ARE YOU HAPPY WITH THE RESULTS? YES/NO IF NO, WOULD YOU LIKE TO KNOW YOUR OPTIONS? YES/NO

DO YOU EVER FEEL, OR HAVE YOU EVER BEEN TOLD THAT YOU DON'T HAVE FRESH BREATH? YES/NO

HOW OFTEN DO YOU BRUSH YOUR TEETH?_____ FLOSS? _____

WHAT TYPE OF TOOTHBRUSH DO YOU USE? SOFT/MEDIUM/HARD

DO YOU AVOID BRUSHING ANY PART OF YOUR MOUTH BECAUSE OF PAIN? YES/NO IF YES, WHICH PART?_____

WHICH FOODS CAUSE YOU TWINGES OF PAIN? HOT/COLD/SWEET/SOUR/NONE DO YOU LOSE/BREAK FILLINGS? YES/NO

DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH? YES/NO IF YES, PLEASE EXPLAIN: _____

DO YOUR GUMS FEEL TENDER OR SWOLLEN? YES/NO DO YOU USUALLY HAVE MANY CAVITIES? YES/NO

DO YOU CLENCH OR GRIND YOUR TEETH WHILE SLEEPING OR DURING THE DAY? YES/NO DO YOUR JAWS EVER FEEL TIRED? YES/NO

We respect your right to choose the level of care that fits your needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums—until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission, we would like to explain the choices available to achieve long–term health and beauty for your existing natural teeth. Please check **all** *that apply:*

- ☐ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- ☐ Spreading payments out over time may help me to achieve the excellent results I desire.
- ☐ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- ☐ I am interested in a plan for long–term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- ☐ Although I am not interested in a plan for long–term dental health, I do desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

ARE YOU DELIGHTED WITH YOUR SMILE? YES/NO PLEASE RATE YOUR SMILE FROM 1–10(1=hate it, 10= love it)_____

WOULD YOU LIKE TO HAVE WHITER TEETH? YES/NO

IF YOU HAD A MAGIC WAND, WHAT, IF ANYTHING, WOULD YOU CHANGE ABOUT YOUR SMILE?_____

WHAT PERSONAL OR PROFESSIONAL BENEFIT(IF ANY) MIGHT YOU GAIN IF YOU HAD A GORGEOUS SMILE?_____

DO YOU HAVE ANY SPECIAL OCCASSIONS COMING UP? YES/NO IF YES, THEN WHAT?_____

Through state of the art technology of Cosmetic Dentistry, we have the ability to help you achieve a World–Class Smile, often overnight... Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements. PRIOR to treatment! Would you like to see what YOU would look like with a new and improved smile? YES/NO
IF YES, PLEASE CIRCLE ALL THAT APPLY:

LIGHTEN ALL FRONT TEETH SHOWING	REBUILD FRACTURE(S)	STRAIGHTEN ROTATION
LIGHTEN SINGLE TOOTH	LENGTHEN	STRAIGHTEN ANGULATION
CLOSE SPACES BETWEEN TEETH	SHORTEN	ELIMINATE CROWDING

Please add anything you feel is important: _____

At BRSH Dental, though our focus is on appearance–related dentistry, we also deliver 99% of your routine dental needs as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long–term results. Thank you so much for the opportunity to be of service.

Warm regards,
MELICIA TJOA