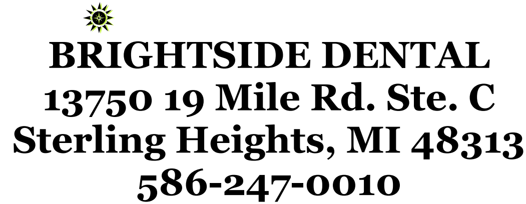

BRIGHTSIDE DENTAL
13750 19 Mile Rd. Ste. C
Sterling Heights, MI 48313
586-247-0010

MEDICAL DENTAL HISTORY FORM

CONFIDENTIAL

Patient's Last Name: ______________ First Name: ______________ Middle: ______________

Name Preferred: _________________ Birth Date: ____________ Age: ______

Sex: ☐ Male ☐ Female S.S.N/S.S.I: ____________

Home Phone: (___) ____-__________ Cell Phone: (____) ____-_________

Email Address: ____

Patient's Address:

____
____
____

Years at above address?: ______

If less than five years at current address, previous address:

____
____
____

Years at previous address?: ______

Patient is: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: ______________ Employer: ______________ Years with Employer: ________

Business phone number: (____) ____-_________

Name of spouse/Closest Relative: _______________________ Phone Number (___) _____-____

Relationship to you: _______________________

Address (if different):

____
____
____

Name of patient's Dentist: ____

Phone: (____) ____-_________

Dentist's Address:

____
____
____

Date last seen: ____________ Reason seen: ____________

Name of patient's physician: ____

Phone: (____)______-________

Physician's address:

____
____
____

Date last seen: ____________ Reason: ___________________________

Who suggested that you might need orthodontic treatment? ______________________________

Why did you select our office? ____

Who is financially responsible for this account? ____

Address (if different from the patient's):

____
____
____

Is there insurance coverage for dental treatment? □ Yes □ No

Is there insurance coverage for orthodontic treatment? □ Yes □ No

Primary policy holder's name: ____
SSN/SSI: __________________ Date of Birth: __________________
Employed By: ____
Dental Insurance Company: ____
Group Number: ____
Secondary Policy Holder's Name: ______________________________ SSN/SSI: ___________
Date of Birth: __________________ Employed By: __________________________________
Dental Insurance Company:______________________ Group Number: _____________________
Medical Insurance Company: ____

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR PATIENTS WHO ARE MINORS (18 AND UNDER), IF YOU ARE OVER 18 PLEASE DISREGARD AND SKIP TO THE NEXT SECTION

What school does your child attend? ________________________________

What grade level? ___________ Musical instruments played? ________

Sports and/or hobbies? ____

Number of brothers and sisters and ages? _____________________________

Other family members treated here? ________________________________

Birth father's height _____ft _____in Birth Mother's height _____ft _____in

Patient's birth weight ___lbs ___oz Patient's present weight ____lbs

Patient's present height ____ft ____in.

Custodial Parent(s) or Guardian(s): _________________________________

Address (if different than parents):

____

____

____

How often do you brush: ___________ Floss:___________

What is your primary concern? Why are you here?

____

____

____

____

I have read and understand the above questions I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ______________________________ Date Signed: ____________________
(Patient) or parent if patient is a minor

Signed: ______________________________ Date Signed: ____________________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments:

Signed: ____________________________ (Patient)
Date Signed: __________________

Signed: ____________________________ (Dental Staff Member)
Date Signed: __________________