Welcome to Brea Family Dental Center

Name:	Home #
Address:	Cell #
City:	Work #
Zip Code:	Email:
SS#	DOB:

If patient is a minor please provide the following information:

Legal Guardian's Name:	SS#	DOB:

Who may we thank for referring you today?: _____

Check appropriate space: Minor ___ Single___ Married___ Divorced___ Widowed___

Is patient a student? _____ If so, school name: _____

Person to contact in case of emergency: _____ Phone #_____

If you are covered by dental insurance please fill out the following:

Ins Co. Name:	Group Name:	Group #
Subscriber Name:	ID or SS #	DOB:
Subscriber's Employer:		
Employer #		
Employer Address:		

If you are covered by secondary dental insurance please fill out the following:

Ins Co. Name:	Group Name:	Group #
Subscriber Name:	ID or SS #	DOB:

Please provide your medical information below:

Physician:	Phone #	Last Visit:
Former Dentist:	Phone #	Last Visit:

Medical History is on the back

Medical and Dental History

	Yes	No
Are you having pain or discomfort at this time?		
Have you ever had a bad experience in a dental office? If yes, please describe:		
Do you feel very nervous about having dental treatment?		
Do your gums bleed when brushing or flossing?		
Have you ever had periodontal treatment?		
Do you clench or grind your teeth?		
Are you being treated for osteoporosis?		
Do you use tobacco?		
Do you use alcohol?		
Have you had any surgery in the past 2 years? If so, explain:		
Are you allergic to any medications or latex products? If so, please list allergies:		
Are you taking any prescription or over the counter medicine? If so, please list current medications:		
Women: Are you pregnant or think you may be pregnant?		

Do you have any or have you had any of the following? Please circle:

1. Rheumatic fever
2. Mitro Valve Prolapse or heart defect
3. Heart attack, angina, heart surgery
4. Artificial joints
5. High blood pressure
6. Stroke
7. Sinus trouble
8. Asthma or hay fever
9. Allergies
10. AIDS or HIV infection
11. Fainting spells or seizures
12. Diabetes
13. Tuberculosis
14. Cancer or leukemia
15. Chemotherapy
16. Radiation therapy
17. Cold sores
17. Sexually transmitted diseases
18. Arthritis
19. Pain in jaw joint
20 Hepatitis

Are there any other health problems not listed above that we should be aware of:

_____

Is there anything you would like to change about the appearance of your teeth? Please describe:

_____

Signature of patient or legal guardian: Date: