The Bright Bite

PATIENT INFORMATION

Patient's Name:_____Sex: (F) (M)

Birth Date:_____/_____/_____

Patient's
Address:_____

City, State, Zip:_____

Phone:_____

Name of Care Facility:_____

Facility Contact Name:_____

Facility Address:_____

City, State, Zip:_____

Phone:_____Fax:_____

Name of Physician:_____

Physician's Address:_____

Name of Dentist:_____

Dentist's Address:_____

City, State, Zip:_____

Phone:_____Fax:_____

The Bright Bite
PO BOX 3607 Covina, CA 91722-3607
Call: 626-808-1114
Allison Cuevas
RDH 26799
RDHAP 712
www.thebrightbite.com

PLEASE CIRCLE THAT APPLY

Heart Trouble/Disease	Yes	No	Diabetes	Yes	No
Heart Murmur	Yes	No	Excessive Thirst	Yes	No
Irregular Heart Beat	Yes	No	Hypoglycemia	Yes	No
Angina/Chest Pain	Yes	No	Liver Disease	Yes	No
Heart Attack/Failure	Yes	No	Hepatitis A (Infectious)	Yes	No
Congenital Heart Disorder	Yes	No	Hepatitis B or C	Yes	No
Mitral Valve Prolapse	Yes	No	Night Sweats	Yes	No
Artificial Heart Valve	Yes	No	Yellow Jaundice	Yes	No
Heart Pace Maker	Yes	No	Kidney Problems	Yes	No
Heart Surgery	Yes	No	Renal Dialysis	Yes	No
High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Low Blood Pressure	Yes	No	Parathyroid Disease	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Blood Disease	Yes	No	Gout	Yes	No
Unexplained Bleeding	Yes	No	Rheumatism	Yes	No
Sickle Cell Anemia	Yes	No	Pain in Jaw Joints	Yes	No
Hemophilia	Yes	No	Cortisone Medicine	Yes	No
Leukemia	Yes	No	Artificial Joint	Yes	No
Recent Blood Transfusion	Yes	No	Venereal Disease	Yes	No
Swelling of Limbs	Yes	No	AIDS	Yes	No
Scarlet Fever	Yes	No	HIV Positive	Yes	No
Rheumatic Fever	Yes	No	Genital Herpes	Yes	No
Lung Disease	Yes	No	Drug Addiction/Alcoholism	Yes	No
Breathing Problem	Yes	No	Cold Sores	Yes	No
Shortness of Breath	Yes	No	Fever Blisters	Yes	No
Frequent Cough	Yes	No	Herpes	Yes	No
Hay Fever	Yes	No	Convulsions	Yes	No
Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Asthma	Yes	No	Fainting or Dizziness	Yes	No
Bloody Sputum	Yes	No	Glaucoma	Yes	No
Emphysema	Yes	No	Nervousness	Yes	No
Tuberculosis	Yes	No	Psychiatric Care	Yes	No
Cancer	Yes	No	Alzheimer's Disease	Yes	No
Tumors or Growths	Yes	No	Allergies (Medicines)	Yes	No
X-Ray Treatments (Radiation)	Yes	No	Allergies (Pollen/Dust)	Yes	No
Chemotherapy	Yes	No	Hives or Rash	Yes	No
Stomach/Intestinal Disease	Yes	No	Premedication Needed?	Yes	No
Ulcers	Yes	No			
Recent Weight Loss	Yes	No			
Frequent Diarrhea	Yes	No			

Describe current or long-term disability/medical condition:_____

_____

Medications:_____

_____

Patient/Custodial/Guardian Signature:_____Date:_____

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