Sea Breeze DENTAL
DR. BRETT BRAZEAL, D.D.S.
5948 Warner Ave., Huntington Beach, CA 92649

WELCOME!

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

First Name_____ Last Name_____ SSN_____ DOB_____

Gender ☐ Female ☐ Male Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Parent/Legal Guardian Name *if minor patient*_____ Relationship to Patient_____

Street Address_____

City_____ State_____ Zip_____

Home #_____ Cell #_____ Email_____

I consent to be contacted on my cell phone listed above for appointment, financial and insurance information. ☐ Yes ☐ No
I may rescind this authorization at any time. If so, I understand my home number and email will be used instead.

Employer_____ Occupation_____

Business Address_____ Business #_____

Business Email_____

Whom may we thank for referring you?_____

In case of emergency, please notify_____ Relationship_____

Home #_____ Cell #_____ Email_____

PRIMARY DENTAL INSURANCE

Subscriber Name_____ SSN_____ DOB_____

Address *if different from patient*_____ Relationship to Patient_____

City_____ State_____ Zip_____

Home #_____ Cell #_____ Email_____

Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

Business Email_____ Business #_____

Insurance Carrier_____ Insurance #_____

Insurance Email_____

Policy #_____ Group #_____ Subscriber #_____

Name of dependent(s) under plan_____

SECONDARY DENTAL INSURANCE

Subscriber Name_____ SSN_____-____-_____ DOB_____

Address *if different from patient*_____ Relationship to Patient_____

City_____ State_____ Zip_____

Home #_____ Cell #_____ Email_____

Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

Insurance Carrier_____ Insurance #_____

Insurance Email_____

Policy #_____ Group #_____ Subscriber #_____

Name of dependent(s) under plan_____

DENTAL HISTORY

What would you like us to do today?_____ Are you in discomfort today? ☐ Yes ☐ No

Former Dentist_____

Address_____ City_____ State_____ Zip_____

Phone#_____ Email_____

Reason for Leaving_____ Date of Last Dental Visit_____ Date of Last X-rays_____

Check ✓ Yes or No if you have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Food collection between teeth	☐	☐	Periodontal treatment	☐	☐	Sensitivity to sweets
☐	☐	Bleeding gums	☐	☐	Grinding or clenching teeth	☐	☐	Sensitivity to cold	☐	☐	Sensitivity when biting
☐	☐	Clicking or popping jaw	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity to hot	☐	☐	Sores or growths in mouth

How often do you brush?_____ How often do you floss?_____

How do you feel about the appearance of your teeth?_____

Have you experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Please describe your dental health or previous treatment_____

MEDICAL HISTORY

Physician_____ Phone #_____

Date of last medical visit_____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please describe_____

	Y	N	
Are you current under physician care?	☐	☐	If yes, describe_____
Have you ever had a blood transfusion?	☐	☐	If yes, give approximate dates_____
Have you ever taken Fen-Phen/Redux?	☐	☐	
WOMEN: Are you currently pregnant?	☐	☐	Nursing? ☐ ☐ Taking birth control pills? ☐ ☐

Check ✓ Yes or No if you have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV positive	☐	☐	Cough, persistent	☐	☐	Herpes	☐	☐	Rheumatic/Scarlet fever
☐	☐	Anaphylaxis	☐	☐	Cough up blood	☐	☐	Hepatitis	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Shortness of breath
☐	☐	Arthritis, rheumatism	☐	☐	Epilepsy	☐	☐	Jaw Pain	☐	☐	Skin rash
☐	☐	Artificial heart valves	☐	☐	Fainting	☐	☐	Kidney disease or malfunction	☐	☐	Spina Bifida
☐	☐	Artificial joints	☐	☐	Food allergies	☐	☐	Liver disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Material allergies	☐	☐	Surgical implant
☐	☐	Atopic (allergy prone)	☐	☐	Headaches			I.e., **latex**, wool, metal, chemicals	☐	☐	Swelling of feet or ankles
☐	☐	Back problems	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐	Thyroid disease or malfunction
☐	☐	Blood disease	☐	☐	Heart problems	☐	☐	Nervous problems	☐	☐	Tobacco habit(s)
☐	☐	Cancer			Describe_____	☐	☐	Pacemaker	☐	☐	Tonsillitis
☐	☐	Chemical dependency	☐	☐	Heart surgery	☐	☐	Psychiatric care	☐	☐	Tuberculosis
☐	☐	Chemotherapy			Describe_____	☐	☐	Rapid weight gain or loss	☐	☐	Ulcer/Colitis
☐	☐	Circulatory problems	☐	☐	Hemophilia or abnormal bleeding	☐	☐	Radiation treatment	☐	☐	Venereal disease
☐	☐	Cortisone treatments				☐	☐	Respiratory disease			

Is the patient currently taking any medications? ☐ Yes ☐ No

If yes, list all:_____

_____

_____

Does the patient have drug allergies? ☐ Yes ☐ No

If yes, list all:_____

_____

_____

ACKNOWLEDGEMENT & AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid for by insurance.

Signature_____ Date_____

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