



 714-203-1023 |  brilliantdenturestudio@gmail.com |  brilliantdenturestudio.com

Welcome to Brilliant Denture & Implant Studio,

Thank you for choosing **Brilliant Denture & Implant Studio** to serve you or your loved one's dental needs. We understand that it may have been some time since your last dental visit, or that accessing dental care has become more challenging due to mobility issues. We want to assure you that we are here to help. Our goal is to provide high-quality, compassionate dental care that can be personalized to your needs.

At **Brilliant Denture & Implant Studio**, we specialize in a range of customizable dentures and implants. We utilize our onsite laboratory to maintain the highest craftsmanship and achieve superior fit and appearance. We are able to offer, in many cases, a new set of dentures in the same week as your initial consultation.. During your initial visit, Dr. Barrett will review your medical history and discuss your dental goals. This step is crucial to understanding how we can best address your needs while ensuring your comfort and safety. You will receive a comprehensive exam, and if necessary, dental x-rays and photographs. Based on the findings, we will provide you with all the information you need to make informed decisions about your treatment. Our team is committed to answering any questions you may have so that you feel confident in your care plan.

Dr. Barrett and the team at **Brilliant Denture & Implant Studio** look forward to providing you or your loved one with the highest level of dental care. Your health and safety are our top priority, and we are dedicated to making your experience as comfortable and stress-free as possible.

For your initial visit, please complete the attached forms and submit them online.

If you have any questions or concerns, please don't hesitate to contact us at: (714) 203-1023.

We look forward to meeting you and providing the care you deserve.

Sincerely,
Dr. Alexa Barrett



PATIENT CONTACT INFORMATION

First Name: _____ Last Name: _____

Date of birth: _____ Age: _____ SSN: _____ Sex: M / F

Address: _____ City: _____ State: _____ ZIP: _____

Home #: _____ Cell#: _____ Email: _____

Parent/Guardian/POA Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home #: _____ Cell#: _____ Email: _____

Name of primary caretaker: _____ Phone #: _____

Who may we thank for referring you to our practice? _____

DENTAL HISTORY

1. What is the reason for your visit today? _____

2. Are you inquiring about having all dental care done under General Anesthesia or IV Sedation? ☐ Yes ☐ No

3. What was the date of your last dental visit: ____/____/____ Dental cleaning: ____/____/____ X-rays: ____/____/____

4. Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

5. Have you ever had orthodontic therapy or worn braces? ☐ Yes ☐ No

6. Are you aware of clenching or grinding your teeth? ☐ Yes ☐ No

7. Do you have:	Yes	No		Yes	No		Yes	No
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Bleeding, sore gums:	☐	☐	Loose teeth:	☐	☐	Unpleasant breath:	☐	☐
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Sensitivity to sweets:	☐	☐	Shifting teeth:	☐	☐	Burning tongue/lips:	☐	☐
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Sensitivity to biting:	☐	☐	Bite Changes:	☐	☐	Clicking jaw:	☐	☐
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Sensitivity to hot/cold:	☐	☐	Food impaction	☐	☐	Locking jaw:	☐	☐
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8. How often do you: Brush ____x's/day ☐ Assisted ☐ Unassisted

Floss ____x's/day ☐ Assisted ☐ Unassisted

Mouthwash ____x's/day ☐ Assisted ☐ Unassisted

9. Do you use a standard or electric toothbrush? ☐ Standard ☐ Electric



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1. Primary Care Physician Name: _____ Phone #: _____

2. Other medical specialist(s) seen within the last 2 years: : _____

3. Are you currently taking any medications? ☐ Yes ☐ No

*If yes, please provide the team with a current medication list at time of appointment.

4. Have you ever had an allergic reaction to any medication or to latex? ☐ Yes ☐ No

Please list medication(s) and adverse effect: _____

5. a. Have you ever taken Fenfluramine/Phentermine (FEN-PHEN) medications? ☐ Yes ☐ No

*If yes, have you ever had an echocardiogram? ☐ Yes Date: ____/____/____ Results: _____

b. Are you taking anticoagulant medication? (Coumadin, Warfarin, Plavix, Ticlid, Heparin) ☐ Yes ☐ No

c. Are you taking or have you ever taken bisphosphonate drugs? (Fosamax, Alendronate) ☐ Yes ☐ No

6. Height: _____ Weight: _____ Do you smoke or use tobacco? ☐ Yes ☐ No

7. Please mark the best answer:

a. Mobility: ☐ No restrictions ☐ Ambulatory Walker ☐ Wheelchair ☐

Non-ambulatory

b. Diet: ☐ No restrictions ☐ Soft Foods ☐ Puree ☐ Feeding Tube

c. I live: ☐ At home ☐ In a Group Home ☐ In a care facility

8. Do you have or have you ever had any of the following (Please check all that apply):

	Yes	No		Yes	No		Yes	No
Alcohol/Drug Abuse	☐	☐	Convulsions/Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐
Hemophilia	☐	☐	Rheumatic Fever	☐	☐	Blood Transfusion	☐	☐
Alzheimer's/Dementia	☐	☐	Diabetes	☐	☐	Pacemaker	☐	☐
Herpes	☐	☐	Psychiatric Care	☐	☐	Heart Murmur	☐	☐
Rheumatism/Arthritis	☐	☐	Dizziness/Fainting	☐	☐	Heart Surgery	☐	☐
Hepatitis (A,B,C)	☐	☐	Sleep Apnea	☐	☐	Liver disease	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐
High Blood Pressure	☐	☐	Stroke	☐	☐	Heart Attack	☐	☐
Artificial Joints/Limbs	☐	☐	Glaucoma	☐	☐	Asthma	☐	☐
STDs	☐	☐	Chest Pain/Heart Disease	☐	☐	Thyroid (Hypo/Hyper)	☐	☐
Kidney Disease	☐	☐	Tuberculosis	☐	☐	Chemo/Radiation	☐	☐
Cancer, Tumors	☐	☐	Headaches, Migraines	☐	☐	HIV/AIDS	☐	☐

Any disease or health concerns not mentioned on the list? _____

