BRIARCLIFF DENTAL GROUP

HEALTH HISTORY & REGISTRATION

Patient's Name: _____ Sex: M F DOB: _____ Age: _____ Date: _____

Home Address: _____ City/State/Zip _____

Please Circle One: Single, Married, Separated, Divorced, Widowed HM # _____ Cell # _____

Your Employer: _____ How Long? _____ Your SSN ___ __ ____ WK# _____

Full Time Student: Yes No If Patient is a minor we need: Mother's DOB: _____ Father's DOB: _____

Name of Spouse (Parent if patient is a minor) _____ Person Responsible for Acct. _____

Spouse's (Parents') Employer: _____ Spouse's SS#: ___ __ ____ WK# _____

Email: _____ EMERGENCY CONTACT INFORMATION: _____

Referred to us by _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

Insured's Employer: _____

Insured's SSN _____ Group # _____

DENTAL HISTORY	YES	NO
How LONG SINCE you have seen a Dentist?		
Are you having PROBLEMS now? WHAT?	☐	☐
Have you had a BAD dental experience in the past?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets or pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems?	☐	☐
Name of previous Dentist:		
Address & Phone#		

MEDICAL HISTORY	YES	NO
Do you have CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now? If yes, for what reason?	☐	☐
Are you currently taking Medications? If yes, What?	☐	☐
Are you pregnant?	☐	☐
Do you smoke?	☐	☐
Do you feel you have bad breath?	☐	☐
Family Physician:		
Phone:		

YES	NO		YES	NO	
☐	☐	Heart Failure	☐	☐	H.I.V. Positive A.I.D.S
☐	☐	Heart Disease or Attack	☐	☐	Hepatitis A (infectious)
☐	☐	Angina Pectoris	☐	☐	Hepatitis B (serum)
☐	☐	High Blood Pressure	☐	☐	Liver Disease
☐	☐	Heart Murmur/MVP	☐	☐	Yellow Jaundice
☐	☐	Rheumatic Fever	☐	☐	Blood Transfusion
☐	☐	Congenital Heart Lesions	☐	☐	Drug Addiction
☐	☐	Scarlet Fever	☐	☐	Hemophilia
☐	☐	Artificial Heart Valve	☐	☐	Fever Blisters
☐	☐	Heart Pacemaker	☐	☐	Epilepsy or Seizures
☐	☐	Heart Surgery	☐	☐	Fainting or Dizzy Spells
☐	☐	Artificial Joints (hip, knee)	☐	☐	Nervousness
☐	☐	Anemia	☐	☐	Psychiatric Treatment
☐	☐	Stroke	☐	☐	Sickle Cell Disease
☐	☐	Kidney Trouble	☐	☐	Glaucoma
☐	☐	Ulcers	☐	☐	Chemotherapy (Cancer, Leukemia)
☐	☐	Cosmetic Surgery	☐	☐	Venereal Disease
☐	☐	Bruise Easily	☐	☐	Tuberculosis (TB)
☐	☐	Emphysema	☐	☐	Hay Fever
☐	☐	Asthma	☐	☐	Allergies or Hives
☐	☐	Sinus Trouble	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Arthritis
☐	☐	X-ray/Cobalt Treatments	☐	☐	Cortisone Medicine
☐	☐	Rheumatism	☐	☐	Alcoholism
☐	☐	Pain in Jaw Joints	☐	☐	Latex Allergy
☐	☐	Bleeding Problems			

Have you ever Pre-medicated for dental treatment? ☐ Yes ☐ No

Are you allergic or have you reacted adversely to any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin	☐	☐	Percodan	☐	☐	Erythromycin
☐	☐	Darvon	☐	☐	Local Anesthetic	☐	☐	Valium
☐	☐	Nitrous Oxide	☐	☐	Codeine	☐	☐	Penicillin

Are you aware of being allergic to any other medication or substance?

☐ Yes ☐ No If yes, please list:

Is there any other Medical or Dental information that you feel we should know about?

CONSENT: The undersigned hereby authorizes the Dentist to take X-ray, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to make a through diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Dentist.

Patient's Signature (Parent of Child): _____ Date _____ Dentist's Signature: _____