

PATIENT INFORMATION

(PLEASE COMPLETE IN INK)

PATIENT

1. NAME: _____
2. ADDRESS: _____
(If PO Box, give street address too)
CITY/STATE/ZIP: _____
3. PHONE: H _____ C _____ W _____
4. DATE OF BIRTH: _____
5. EMPLOYER: _____
(Business Name if Self-Employed)
ADDRESS: _____
CITY/STATE/ZIP: _____
6. SOCIAL SECURITY NO: _____
7. WHOM MAY WE THANK FOR REFERRING YOU?

(Name)
8. WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?
FAMILY MEMBER _____
CLOSEST FRIEND _____
9. CHECK ONE: MARRIED _____ UNMARRIED _____
SEPARATED _____ WIDOWED _____

PATIENT'S SPOUSE, PARENT OR GUARDIAN

10. NAME: _____
11. ADDRESS: _____
(If different than patient's)
CITY/STATE/ZIP: _____
12. PHONE: H _____ W _____
13. DATE OF BIRTH: _____
14. EMPLOYER: _____
(Business Name if Self-Employed)
ADDRESS: _____
CITY/STATE/ZIP: _____
15. SOCIAL SECURITY NO: _____
16. ARE YOU COVERED BY DENTAL INSURANCE?
YES _____ NO _____
If your answer is yes, please complete the information below.
17. PATIENT EMAIL ADDRESS: _____

INSURANCE INFORMATION

Patients with insurance are responsible for payment of their bills. It is not always possible to predict which services are covered by the carrier or how much they will pay for a particular service. The office will assist you in every way possible with your insurance carrier.

FIRST INSURANCE CO.

1. EMPLOYEE'S NAME 1. _____
2. EMPLOYEE'S SOCIAL SECURITY NO. 2. _____ - _____ - _____
3. EMPLOYEE'S SEX 3. MALE _____ FEMALE _____
4. EMPLOYEE'S DATE OF BIRTH 4. _____
5. INSURANCE CO. NAME 5. _____
6. INSURANCE CO. ADDRESS 6. _____
CITY: _____
7. GROUP PLAN # 7. _____
8. LOCAL UNION # 8. _____
9. POLICY # (OR P.O.E.#) 9. _____
10. EMPLOYER'S NAME 10. _____
(BUSINESS NAME IF SELF-EMPLOYED)
11. EMPLOYER'S ADDRESS 11. _____
CITY: _____
12. FAMILY MEMBERS COVERED 12. _____ - _____
NAME BIRTHDATE

SECOND INSURANCE CO. (IF COVERED BY MORE THAN ONE INSURANCE)

1. _____
2. _____ - _____ - _____
3. MALE _____ FEMALE _____
4. _____
5. _____
6. _____
CITY: _____
7. _____
8. _____
9. _____
10. _____
(BUSINESS NAME IF SELF-EMPLOYED)
11. _____
CITY: _____
12. _____ - _____
NAME BIRTHDATE

DR. STEVEN J. PIERCE, D.D.S., P.A.
HEALTH HISTORY
(PLEASE COMPLETE IN INK)

DR. # _____
OFFICE USE

01/00

Patient's Name: _____ How do you prefer to be addressed? _____

Answers to the following questions are for our records only and will be considered confidential.

- 1. Date of last Physical Examination _____ Physician's Name _____
2. Date of last Dental Examination _____ Previous Dentist's Name/Phone No. _____
3. Date of Last Dental X-Rays _____ CIRCLE
4. Are you having pain or discomfort at this time? ... YES NO
5. Do you feel very nervous about having dental treatment? ... YES NO
6. Have you ever had a bad experience in the dental office? ... YES NO
7. Is there anything that you dislike about your smile? ... YES NO
8. Is there anything that you would like to change about your smile? ... YES NO
9. Have you been a patient in the hospital during the past two years? ... YES NO
10. Have you been under the care of a medical doctor during the past two years? ... YES NO
11. Have you taken any medicines or drugs in the last two years? If so, which ones? ... YES NO

- 12. Have you ever taken the PhenFen drug? ... YES NO
13. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs, medications, metals, or latex? ... YES NO
If yes, explain: _____

- 14. Have you ever had any excessive bleeding requiring special treatment? ... YES NO

15. Circle any of the following which you have had or have at present:

- Heart Failure Kidney Trouble Arthritis Venereal Disease (Syphilis, Gonorrhea)
Heart Disease or Attack Ulcers Rheumatism Cold Sores
Angina Pectoris Mental Retardation Cortisone Medicine Herpes
High Blood Pressure Emphysema Glaucoma Epilepsy or Seizures
Heart Murmur Cough Pain in Jaw Joints Fainting or Dizzy Spells
Rheumatic Fever Tuberculosis (TB) Birth Defects Nervousness
Congenital Heart Lesions Asthma HIV Positive, ARC, AIDS Psychiatric Treatment
Scarlet Fever Hay Fever Hepatitis A (infectious) Sickle Cell Disease
Artificial Heart Valve Sinus Trouble Hepatitis B (serum) Bruise Easily
Heart Pacemaker Allergies or Hives Liver Disease Use of Tobacco Products
Heart Surgery Diabetes Yellow Jaundice Alcoholism
Artificial Joint Thyroid Disease Blood Transfusion
Anemia X-ray or Cobalt Treatment Drug Addiction
Stroke Chemotherapy (Cancer, Leukemia) Hemophilia CIRCLE

- 16. Have you ever had any instructions in oral hygiene? ... YES NO
17. Are there now any growths or sores in or around your mouth? ... YES NO
18. Do you have any trouble chewing? ... YES NO
19. Does food catch between your teeth? ... YES NO
20. Do you have pain in or near your eyes? ... YES NO
21. Do you habitually clench or grind your teeth during the day or night? ... YES NO
22. Do you snore? ... YES NO
23. Have you ever been told that you have gum problems? ... YES NO
24. Do you now have bleeding gums or any other gum problems? ... YES NO
25. WOMEN: Are you pregnant now? (Please inform us before X-rays are taken? ... YES NO
26. Is there anything related to your medical or dental history that you have not indicated above? If yes, explain ... YES NO
27. Purpose of this dental visit? _____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize a credit history report. If I am delinquent in paying my account, I agree to pay an 1.5% monthly rebilling charge to cover the costs of repeated billing procedures. (Military only: I give my permission for you to talk to my superiors if I am delinquent in paying my account.)

I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis or treatment by Dr. Steven Pierce.

SIGNATURE: _____ Date _____

COMPLETE FOR SUBSEQUENT VISITS ONLY: I have read my answers to the health history questions listed above and there are no changes.

(1) _____ (2) _____ (3) _____ (4) _____
INITIALS DATE INITIALS DATE INITIALS DATE INITIALS DATE