PIERZ FAMILY DENTISTRY

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Welcome to our office…

In order to provide proper treatment, we will need the following information. All information is confidential.

PATIENT INFORMATION

Today's Date_____ Cell Phone_____ Home Phone_____

Patient_____
Last First M.I. Preferred Name/Nickname

Address_____City_____ Zip_____

Email_____ Sex M F Age_____Birthdate_____

Parent(s) or Guardian (if patient is under 18) _____

In Case of emergency, contact_____Phone_____

Relationship to patient _____

BILLING INFORMATION • INSURANCE INFORMATION

Dental Insurance: Yes No If yes, please present card

If no insurance, Responsible Party to be billed_____

Dental Insurance Company_____ Subscriber ID _____Group #_____

Policy Holder Name _____

Policy Holder Date of Birth _____Policy holder Social Security Number_____

Relationship to Policy Holder_____

Secondary Insurance: Yes No If yes, please present card

Dental Insurance Company_____ Subscriber ID _____Group #_____

Policy Holder Name _____

Policy Holder Date of Birth _____Policy holder Social Security Number_____

Relationship to Policy Holder_____

Do you have Medical Assistance through the county or state: Yes No

PATIENT MEDICAL HISTORY

Do you have, or have you ever had any of the following?

Yes	No		Yes	No	
□	□	Penicillin allergy	□	□	Rheumatic Fever
□	□	Sulfa allergy	□	□	Tuberculosis
□	□	Local anesthesia allergy	□	□	High blood pressure
□	□	Codeine allergy	□	□	High Cholesterol
□	□	Aspirin allergy	□	□	Asthma
□	□	Latex allergy	□	□	Hepatitis Type_____ Liver disease, jaundice
□	□	Other allergies_____			
□	□	PreMed required (Heart, artificial joints)	□	□	Epilepsy, seizures, convulsions
□	□	Heart valve replacement Date_____	□	□	AIDS, HIV positive
□	□	Heart bypass, Date_____	□	□	Glaucoma
□	□	Heart Attack, Date_____	□	□	Bone Density Meds (Boniva, Fosamax, etc) Date started_____
□	□	Pacemaker			
□	□	Other heart problems (Please List) _____	□	□	Chemical Dependency (drugs, alcohol)
□	□	Stroke, Date_____			
□	□	Joint Replacement Date/Type_____	□	□	Tobacco products ____Chewing tobacco ____Smoker/Vape
□	□	Blood Thinners (Warfarin,Xarelto,Eloquis)			
□	□	Bleeding tendency	□	□	Neurocognitive Disorder (Alzheimer,Dementia, Parkinsons)
□	□	Diabetes, Type_____			
□	□	Cancer Date/Type_____	□	□	Mental Health Disorder
			□	□	Auto Immune Disorders (Lupus, Crohns, RA, MS etc
□	□	IV Chemo, Date_____			

□ **Yes** □ **No** (Women) Are you taking oral contraceptives
□ **Yes** □ **No** (Women) Do you suspect you may be pregnant?
□ **Yes** □ **No** Have you had any of the following in the past two years?

Serious illness_____
Hospitalization_____
Surgery_____

□ **Yes** □ **No** Are you under a physician's care at this time?
If yes, for what condition(s)?_____
Who is your physician, and where is he/she located?_____

□ **Yes** □ **No** Are you taking any medications? Please List

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Signature_____ Date_____

Signature_____ Date_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance benefits to which I am entitled