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. EMAIL ADDRESS: _____
5. DATE OF BIRTH: _____
6. EMPLOYER: _____
   (Business Name if Self-Employed)
   ADDRESS: _____
   CITY/STATE/ZIP: _____
7. SOCIAL SECURITY NO: _____

   _____
   (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. WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

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

PIERCE & KNIGHT FAMILY DENTISTRY
HEALTH HISTORY

(PLEASE COMPLETE IN INK)

01/00

DR. # _____
OFFICE USE

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/Phone No. _____
2. Date of last Dental Examination _____ Previous Dentist's Name/Phone No. _____
3. Date of Last Dental X-Rays _____

CIRCLE

4. Is there anything that you dislike about your smile? ..... YES NO
5. Is there anything that you would like to change about your smile? ..... YES NO
6. Have you ever had a bad experience in the dental office? ..... YES NO
7. Are you having pain or discomfort at this time? ..... YES NO
8. Do you feel very nervous about having dental treatment? ..... 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	Developmental Delays	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 Disease	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	Sleep Apnea
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 acknowledge that I am responsible for information 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. Robert Pierce and/or Dr. Ashley Knight.

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