PIERZ FAMILY DENTRISTRY, PLLC

Andrea McGrew, DDS & Chris McGrew, DDS
PO Box 68 ♦ 116 Main Street ♦ Pierz, MN 56364 ♦ (320) 468-2379

Welcome to our office...

In order to provide proper treatment we will need the following information.
All information will be strictly confidential.

PATIENT INFORMATION

Today's Date _____ Cell Phone _____ Home Phone _____

Patient _____
Last First M.I. Preferred Name/Nickname

Address _____ City _____ State _____ Zip _____

Email Address _____ Sex: ☐ M ☐ F Age _____ Birth Date _____

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

In case of emergency, contact _____ Phone _____

BILLING INFORMATION

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Work Phone _____

Spouse/Partner Name _____

Employed by _____ Occupation _____

Business Address _____ Work Phone _____

INSURANCE INFORMATION

Name of Insured _____ Social Security Number: _____

Date of Birth for Policy Holder _____-_____-_____

Dental Insurance: ☐ Yes ☐ No If yes, please present card.

Secondary Insurance: ☐ Yes ☐ No If yes, please present card.

(PLEASE FILL OUT BOTH SIDES OF THIS FORM)

PATIENT MEDICAL HISTORY

Please answer EACH question. Thank you.

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

Yes	No		Yes	No	
☐	☐	Penicillin allergy	☐	☐	Rheumatic Fever
☐	☐	Sulfa allergy	☐	☐	Prosthetic Joints (such as knee or hip replacement)
☐	☐	Local anesthesia allergy			
☐	☐	Codeine allergy	☐	☐	High blood pressure
☐	☐	Aspirin allergy	☐	☐	Asthma
☐	☐	Latex allergy	☐	☐	Hepatitis, liver disease, or jaundice
☐	☐	Other allergies _____			
☐	☐	Heart valve replacement	☐	☐	Convulsions, seizures or epilepsy
☐	☐	Heart by-pass surgery	☐	☐	AIDS or HIV positive
☐	☐	Heart Attack	☐	☐	Chemical dependency
☐	☐	Pacemaker	☐	☐	Glaucoma
☐	☐	Other heart problems *(list below)*	☐	☐	I.V. Chemotherapy
☐	☐	Tuberculosis	☐	☐	Bone Density Medications (Boniva, Fosamax, etc)
☐	☐	Bleeding tendency (such as abnormal bleeding from a cut)	☐	☐	Do you use tobacco products
☐	☐	Diabetes			

Yes	No	
☐	☐	(Women) Are you taking oral contraceptives?
☐	☐	(Women) Do you suspect that you may be pregnant?

Have you had any of the following in the past two years?

Yes	No	
☐	☐	Serious illness _____
☐	☐	Hospitalization _____
☐	☐	Surgery _____

Are you under a physician's care at this time?

Yes	No	
☐	☐	If yes, for what condition(s)? _____

_____

Who is your physician, and where is he/she located?

_____

Yes	No	
☐	☐	Are you taking any medications?

If yes, please list what they are, and why you take them.

_____ _____

_____ _____

_____ _____

_____ _____

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

Signature _____ Date _____

Signature _____ Date _____

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