Mark M Bierma

DDS • MS • PLLC

Endodontic Specialist

Patient Information

Date _____

SSN _____

Patient Name_____

Address_____

City_____

State_____ Zip_____

Sex ☐ Male ☐ Female

Age_____ Birthdate_____

Employer_____

Occupation_____

Employer Address_____

_____

Phone Numbers

Home_____

Cell _____

Work _____

Preferred Time and Number to Call _____

Emergency Contact

Please list someone outside of your household

Name_____

Relationship_____

Home Ph _____

Cell Ph _____

Work Ph_____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Group # _____

Please complete the following if the subscriber is someone other than the patient:

Subscriber's Name_____

Subscriber's SSN _____

Subscriber's Birthdate _____

Subscriber's Employer _____

Relationship to Patient_____

Assignment of Dental Insurance

I hereby certify that I have dental insurance through

_____

(Name of Insurance Company)

and hereby assign all insurance benefits to Dr. Mark M Bierma. I authorize the use of my signature for all insurance submissions. I realize that I am financially responsible for any charges whether or not they are paid by an insurance company. I hereby authorize the practice of Dr. Mark M Bierma to use my private health care information for the purpose of determining and obtaining dental insurance benefits. I understand this consent will expire when I revoke it, or one year from the signing of this document, whichever comes first.

_____

Signature of Patient, Parent, or Guardian

_____

Printed Name of Patient, Parent, or Guardian

_____ _____

Date Relationship to Patient

Dental History

Reason for today's visit_____

_____

Dentist:_____

City/State:_____

Date of last dental visit_____

Date of last dental X-rays_____

Pain History

Do you have dental pain? ☐ Yes ☐ No

When did your pain begin? _____

Is the pain . . . ☐ Increasing ☐ Decreasing ☐ Not Changing

Where do you feel pain? _____

Do any or all of the following trigger your pain:

☐ Cold ☐ Heat ☐ Chewing ☐ Touch

Does your pain begin spontaneously? ☐ Yes ☐ No

Which one of the following describes your pain:

☐ Constant ☐ Intermittent ☐ Fluctuating

How would you describe your pain:

☐ Dull Ache ☐ Throbbing ☐ Sharp Shooting

Does anything relieve your pain? _____

Please mark your present pain level on the line below:

0———————5———————10

(no pain) (extreme pain)

Please mark the highest level of pain you have experienced from this tooth:

0———————5———————10

(no pain) (extreme pain)

Please Turn Over

Health History - Please circle any items which you do not understand and Dr. Bierma will review them with you.

Physician's Name_____

Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phenteermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type____	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

Are you or have you taken Bisphosphonates? ☐ Yes ☐ No

Examples: Fosamax, Aredia, Boniva, Zometa, Aclasta, Bonefos, Didronel, Reclast, Skelid

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy Name_____

Phone(___)_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping Pills)

☐ Codeine ☐ Penicillin

☐ Iodine ☐ Sulfa

☐ Latex

☐ Other_____

Privacy Practices (HIPAA)

I acknowledge that I have reviewed a copy of Dr. Mark Bierma's Privacy Practices to my satisfaction.

Patient's Signature_____ Date_____