Krueger Dental Associates

NEW PATIENT INFORMATION AND HISTORY

PATIENT INFORMATION

Today's Date

Patient's Name: _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

Sex: [ ] Female [ ] Male Birth date: ____/____/____ Age:_____

[ ] Single [ ] Married [ ] Widowed [ ] Minor [ ] Separated [ ] Divorced [ ] Partnered for ____ years

S.S #: _____ E-mail Address: _____

EMERGENCY CONTACT PREFERENCE

In case of an emergency, Contact (specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

DENTAL INSURANCE BENEFIT

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Co: _____ Group #: _____

Subscriber's Name: _____ Birth date: ____/____/____ S.S.#: _____

Employer Name: _____

Is patient covered by additional insurance? [ ] Yes [ ] No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. Krueger all insurance benefits, if any, otherwise payable to me for services rendered. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I authorize the use of my signature for all electronic submissions, including but not limited to, insurance, x-rays, treatments and medications.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
Signature of Patient, Parent, Guardian or personal representative Please Print Name

_____ _____
Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____ Phone #: _____ City/State: _____

Date of last dental visit: _____ Date of last dental X-rays: _____

How often do you Floss? _____ How often do you brush? _____

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

Bad breath	☐ YES	☐ NO	Grinding teeth	☐ YES	☐ NO
Bleeding gums	☐ YES	☐ NO	Loose or broken fillings	☐ YES	☐ NO
Blisters on lips or mouth	☐ YES	☐ NO	Mouth breathing	☐ YES	☐ NO
Burning sensation on tongue	☐ YES	☐ NO	Mouth pain while brushing	☐ YES	☐ NO
Chew on one side of mouth	☐ YES	☐ NO	Orthodontic treatment	☐ YES	☐ NO
Use smokeless tobacco, cigars or pipe	☐ YES	☐ NO	Pain around ear	☐ YES	☐ NO
Clicking or popping jaw	☐ YES	☐ NO	Periodontal treatment	☐ YES	☐ NO
Food collection between teeth	☐ YES	☐ NO	Sensitivity to cold or heat	☐ YES	☐ NO
Grinding teeth	☐ YES	☐ NO	Sensitivity to sweets	☐ YES	☐ NO
Swollen or tender Gums	☐ YES	☐ NO	Sensitivity when biting	☐ YES	☐ NO
Food collection between teeth	☐ YES	☐ NO	Sores or growths in mouth	☐ YES	☐ NO

COSMETIC CONCERNS

Check all that apply

Teeth whitening	☐	Gaps between teeth	☐
Unsightly Crowns	☐	Unsightly Fillings	☐
Crooked Teeth	☐	Other: _____	

HEALTH HISTORY

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 Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐YES ☐NO

Have you ever taken any bone strengthening drugs for Osteoporosis or Cancer related bone problems? Such as Fosamax, Boniva, Actonel, Zometa, Reclast, Aredia, Nerixia and Xgeva. ☐YES ☐NO

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

AIDS/HIV	☐YES	☐NO	Emphysema	☐YES	☐NO	Respiratory Disease	☐YES	☐NO
Anemia	☐YES	☐NO	Epilepsy	☐YES	☐NO	Rheumatic Fever	☐YES	☐NO
Arthritis, Rheumatism	☐YES	☐NO	Fainting or dizziness	☐YES	☐NO	Scarlet Fever	☐YES	☐NO
Artificial Heart Valves	☐YES	☐NO	Glaucoma	☐YES	☐NO	Shortness of Breath	☐YES	☐NO
Artificial Joints	☐YES	☐NO	Headaches	☐YES	☐NO	Sinus Trouble	☐YES	☐NO
Asthma	☐YES	☐NO	Heart Murmur	☐YES	☐NO	Skin Rash	☐YES	☐NO
Back Problems	☐YES	☐NO	Heart Problems	☐YES	☐NO	Special Diet	☐YES	☐NO
Bleeding Abnormally, with extractions or surgery	☐YES	☐NO	Hepatitis Type _____	☐YES	☐NO	Stroke	☐YES	☐NO
			Herpes	☐YES	☐NO	Swollen Feet or Ankles	☐YES	☐NO
Blood Disease	☐YES	☐NO	High Blood Pressure	☐YES	☐NO	Swollen Glands	☐YES	☐NO
Cancer	☐YES	☐NO	Jaundice	☐YES	☐NO	Thyroid Problems	☐YES	☐NO
Chemical Dependency	☐YES	☐NO	Jaw Pain	☐YES	☐NO	Tonsillitis	☐YES	☐NO
Smoking : How much:_____ or			Kidney Disease	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Alcohol consumption: Frequency_____			Liver Disease	☐YES	☐NO	Tumor or Growth on	☐YES	☐NO
Chemotherapy	☐YES	☐NO	Low Blood Pressure	☐YES	☐NO	Head or Neck		
Circulatory Problems	☐YES	☐NO	Mitral Valve Prolapse	☐YES	☐NO	Ulcer	☐YES	☐NO
Congenital Heart Lesions	☐YES	☐NO	Nervous Problems	☐YES	☐NO	Venereal Disease	☐YES	☐NO
Cortisone Treatments	☐YES	☐NO	Pace Maker	☐YES	☐NO	Weight Loss, unexplained	☐YES	☐NO
Cough, persistent or bloody	☐YES	☐NO	Psychiatric Care	☐YES	☐NO			
Diabetes	☐YES	☐NO	Radiation Treatment	☐YES	☐NO	Other: _____		
Do you wear contact lenses?	☐YES	☐NO						

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: (INCLUDE over-the-counter herbals and vitamins)

_____
_____
_____
_____
_____
_____

Pharmacy name: _____
Phone (_____)_____

ALLERGIES

- ☐Aspirin
- ☐Barbiturates (Sleeping Pills)
- ☐Codeine
- ☐Iodine
- ☐Latex
- ☐Local Anesthetic
- ☐Penicillin
- ☐Sulfa
- ☐Other: _____

SLEEP QUESTIONS:

Do you snore or have you been told in the past that you snore?	☐YES	☐NO	Do you currently wear a CPAP?	☐YES	☐NO
Do you regularly have excessive daytime sleepiness?	☐YES	☐NO			
Have you been told you gasp for breath while sleeping?	☐YES	☐NO	Do you find it difficult to comply with your CPAP?	☐YES	☐NO
Have you ever done a sleep study or been diagnosed with Sleep Apnea?	☐YES	☐NO			

OTHER: (Comments and/or Questions)

_____
_____
_____