Douglas A. Krueger, D.D.S

821 E. First Ave. Suite 1
Appleton, WI 54911
(920) 734-2414

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: ________________________________, Last Name: ______________________________________ First Name: ____________________________

Preferred to be called: _______________, Mailing Address: ____

Home Phone: __________________________, Work Phone: ____________________________________ Cell Phone: ___________________________________

City, State, Zip: ____ Date of Birth: ____

SS#: ________________________________, Driver's License: ____________________________________ Sex: __M____F_ Occupation: __________________

Employer: ____, Address, City State, Zip ____

Emergency Contact Name: ____ Phone # : ____

Spouse's Name: ____ Occupation: ____

Spouse's Address (if different than above): ____, City, State, Zip: _____________________________

Spouse's Employer: _______________________________________ Address, City, State, Zip: ____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: ____, Place__________________________________ Time: __________________

INSURANCE INFORMATION:

Primary Insurance Company : ____ Address: ____

City: _________________________________ State: _________________ Zip: ____________________ Phone #: ____

Policy Holder Name: ____ SS#: __________________________________ Birth date: ________________________

Group# or Policy # ____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Krueger of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: ____________________________ Patient's Signature: ____

MEDICAL HEALTH HISTORY PATIENT NAME: ________________________

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: ____
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: ______________________________________

---

4. Yes No Are you being treated by a physician now? For what? ____

Name of your physician: ____ Date of last Medical Exam: ______________________________

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Diarrhea, constipation, blood in stools
14. Yes No Frequent vomiting, nausea
15. Yes No Difficulty urinating, blood in urine
16. Yes No Dizziness
17. Yes No Ringing in ears
18. Yes No Frequent Headaches
19. Yes No Fainting spells
20. Yes No Blurred Vision
21. Yes No Seizures
22. Yes No Excessive thirst
23. Yes No Frequent urination
24. Yes No Dry Mouth
25. Yes No Jaundice
26. Yes No Joint pain, stiffness
27. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

28. Yes No Heart disease
29. Yes No Heart attack, heart defects
30. Yes No Heart murmur
31. Yes No Rheumatic fever
32. Yes No Stroke, hardening of arteries
33. Yes No High Blood Pressure
34. Yes No TB, emphysema or other lung diseases
35. Yes No Hepatitis, A B C
36. Yes No Stomach problems, ulcers
37. Yes No Diabetes
38. Yes No Family History of diabetes, heart problems, cancer
39. Yes No HIV positive or AIDS-ARC
40. Yes No Tumors, Cancer
41. Yes No Arthritis, rheumatism
42. Yes No Eye disease
43. Yes No Skin disease
44. Yes No Anemia
45. Yes No VD (syphilis or gonorrhea)
46. Yes No Herpes
47. Yes No Kidney, bladder diseases
48. Yes No Thyroid, adrenal diseases
49. **ALLERGIES**: to drugs, food, medications, metals, jewelry, acrylics; **list the following allergies:**

____

____

D. DO YOU HAVE OR HAVE YOU HAD:

50. Yes No Surgeries ________________________________
51. Yes No Blood Transfusions __________________________
52. Yes No Artificial Joint ______________________________
53. Yes No Contact Lenses ____________________________
54. Yes No Psychiatric Care ___________________________
55. Yes No Radiation Treatments
56. Yes No Chemotherapy
57. Yes No Prosthetic heart valve
58. Yes No Pacemaker
59. Yes No **Women only**: Birth Control Pills
60. Yes No **Women only: Pregnant or nursing**

E. DO YOU TAKE:

61. Yes No Recreational drugs
62. Yes No Alcohol
63. Yes No Tobacco in any forms

F. ALL PATIENTS:

64. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

____

65. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment and why?

PLEASE <u>LIST ANY MEDICATIONS</u> YOU MAY BE ON AND ANY <u>ADDITIONAL COMMENTS</u>:

____

____

DENTAL HEALTH HISTORY **DATE: ______________________**

66. Name of Previous Dentist: ____ How long since you were last seen? ___________________
67. Is keeping your teeth important to you? [Y] [N] If yes, why? ____
68. On a scale of 1-10, 10 being the best, where would you rate your smile?
69. On a scale of 1-10, 10 being the best, where you rate your oral health?
70. Have you experienced any of the following problems:

Bleeding gums [Y] [N],	Sensitivity to Hot & Cold [Y] [N]
Bad Breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensations in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N],	Grinding of Teeth [Y] [N]
Is it hard for you to open wide? [Y] [N]	Pain/soreness around ears, eyes, face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Had your parents suffered from Gum Disease? [Y] [N]	Did you parents wear dentures/partials? [Y] [N]
Did you ever wear braces? [Y] [N]	Ever been injured in your mouth or head? [Y] [N]
Oral Surgery of any kind? [Y] [N]	Do you smoke or chew tobacco? [Y] [N]

71. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?___________________________

____

72. Is the brightness of your teeth important to you? [Y] [N]

73. If you could change anything about your smile which of the following would you want] ?

Whiter [Y] [N],	Close space or spaces [Y] [N],	Replace chipped teeth [Y] [N]
Replace missing teeth [Y] [N]	Replace old crowns [Y] [N]	Remove silver fillings [Y] [N]
Remove Stains/Spots on teeth [Y] [N]	Excess showing of Teeth [Y] [N]	Replace old plastic filling(s) [Y] [N]
Straighter [Y] [N]	Less Gum showing [Y] [N]	Reshape/resize my teeth [Y] [N]

74. Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years?

Please circle the following which are important to you when making your dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of Care
What insurance covers	Health	Detailed Treatment Explanations
Fear or Anxiety	Comfort	Technology