

Douglas A. Krueger, D.D.S

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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 | 16. Yes No Dizziness |
| 6. Yes No Swollen Ankles | 17. Yes No Ringing in ears |
| 7. Yes No Shortness of breath | 18. Yes No Frequent Headaches |
| 8. Yes No Recent weight loss, fever, night sweats | 19. Yes No Fainting spells |
| 9. Yes No Persistent cough, coughing up blood | 20. Yes No Blurred Vision |
| 10. Yes No Bleeding problems, bruising easily | 21. Yes No Seizures |
| 11. Yes No Sinus Problems | 22. Yes No Excessive thirst |
| 12. Yes No Difficulty swallowing | 23. Yes No Frequent urination |
| 13. Yes No Diarrhea, constipation, blood in stools | 24. Yes No Dry Mouth |
| 14. Yes No Frequent vomiting, nausea | 25. Yes No Jaundice |
| 15. Yes No Difficulty urinating, blood in urine | 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 | 39. Yes No HIV positive or AIDS-ARC |
| 29. Yes No Heart attack, heart defects | 40. Yes No Tumors, Cancer |
| 30. Yes No Heart murmur | 41. Yes No Arthritis, rheumatism |
| 31. Yes No Rheumatic fever | 42. Yes No Eye disease |
| 32. Yes No Stroke, hardening of arteries | 43. Yes No Skin disease |
| 33. Yes No High Blood Pressure | 44. Yes No Anemia |
| 34. Yes No TB, emphysema or other lung diseases | 45. Yes No VD (syphilis or gonorrhea) |
| 35. Yes No Hepatitis, A B C | 46. Yes No Herpes |
| 36. Yes No Stomach problems, ulcers | 47. Yes No Kidney, bladder diseases |
| 37. Yes No Diabetes | 48. Yes No Thyroid, adrenal diseases |
| 38. Yes No Family History of diabetes, heart problems, cancer | 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 _____ | 55. Yes No Radiation Treatments |
| 51. Yes No Blood Transfusions _____ | 56. Yes No Chemotherapy |
| 52. Yes No Artificial Joint _____ | 57. Yes No Prosthetic heart valve |
| 53. Yes No Contact Lenses _____ | 58. Yes No Pacemaker |
| 54. Yes No Psychiatric Care _____ | 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 LIST ANY MEDICATIONS YOU MAY BE ON AND ANY ADDITIONAL COMMENTS:

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 |