PATIENT INFORMATION FORM

NAME: ____ BIRTHDATE: ____________________ AGE: ______
ADDRESS: ____ CITY: __________________ ZIP: ___________
E-MAIL: ______________________________________ SOCIAL SECURITY NUMBER:__________________
PREFERRED PHONE: _______________________ WORK PHONE: ___________________________________
MARITAL STATUS: _____________________________ SPOUSE'S NAME: ____________________________
IF PATIENT IS A MINOR, NAME OF PARENT/GUARDIAN: ____
NAME OF PHARMACY: _________________________________ PHONE NUMBER: _____________________
OCCUPATION: _______________________________ EMPLOYER: ___________________________________
BUSINESS ADDRESS: ___________________________________ BUSINESS PHONE: __________________
REFERRED BY: __________________________________ CITY: ____________________________________
NAME OF DENTIST: _____________________________ CITY: ____________________________________
HAVE YOU, OR ANY MEMBER OF YOUR FAMILY, SEEN DR. KRUEGER BEFORE? NAME: _________________

IF YOU HAVE DENTAL INSURANCE, PLEASE GIVE YOUR CARD TO THE RECEPTIONIST.

NAME OF YOUR PHYSICIAN: _________________________________ CITY: _________________________
DATE OF LAST EXAM: _________________________ FINDINGS: ___________________________________
HOW IS YOUR GENERAL HEALTH? ____

DO YOU CLENCH OR GRIND YOUR TEETH? YES NO
HAVE YOU HAD ANY PERIODONTAL TREATMENT? YES NO
HAVE YOU HAD SURGERY OR **X-RAY TREATMENT** (RADIATION) FOR ANY TUMOR, GROWTH, OR OTHER CONDITION OF YOUR HEAD, MOUTH OR LIPS? YES NO
ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO
PHYSICALS ONLY? OTHER? ____
HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR MAJOR SURGERY? YES NO
HAVE YOU HAD ANY ABNORMAL BLEEDING WITH TOOTH EXTRACTION, SURGERY OR TRAUMA? YES NO
HAVE YOU EVER TAKEN AREDIA OR ZOMETA (CANCER DRUG)? YES NO
PLEASE LIST ANY DRUGS YOU HAVE TAKEN WITHIN THE PAST YEAR: ______________________________
____
HAVE YOU EVER HAD ANY ALLERGIES (FOOD, POLLEN, DUST, DRUGS)? YES NO
ARE YOU ALLERGIC TO, OR HAVE YOU HAD AN ADVERSE REACTION TO, ANY OF THE FOLLOWING:

- DENTAL ANESTHETIC (NOVOCAINE, ETC.) YES NO
- PENICILLIN OR OTHER ANTIBIOTICS? YES NO
  - IF YES, WHAT ANTIBIOTIC AND WHAT REACTION? ___________________________________
- BARBITURATES YES NO
- LATEX YES NO
- CODEINE YES NO
- OTHER: ____

HAVE YOU EVER BEEN TREATED FOR OSTEOPOROSIS OR TAKEN BISPHOSPHONATES, SUCH AS BONIVA, ACTONEL, FOSAMAX OR RECLAST? WHAT DOSAGE/FREQUENCY? __________________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

CONGENITAL HEART LESION	YES	NO	RHEUMATIC FEVER	YES	NO
HEART TROUBLE/ATTACK	YES	NO	ABNORMAL BLOOD COUNT	YES	NO
CORONARY INSUFFICIENCY	YES	NO	STROKE	YES	NO
HIVES OR SKIN RASH	YES	NO	TUMOR OR GROWTH	YES	NO
HEART MURMUR	YES	NO	FREQUENT HEADACHES	YES	NO
SEISURES OR CONVULSIONS	YES	NO	HEPATITIS/LIVER DISEASE	YES	NO
PACEMAKER/DEFIBRILLATOR	YES	NO	TUBERCULOSIS	YES	NO
IMPLANTS/JOINT REPLACEMENTS	YES	NO	EMPHYSEMA	YES	NO
THYROID/PARATHYROID DISEASE	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTERIOSCLEROSIS	YES	NO	MITRAL VALVE PROLAPSE	YES	NO

OVER

ULCERS	YES	NO	HIV	YES	NO
TENDENCY TO FAINT	YES	NO	EPILEPSY	YES	NO
DIABETES	YES	NO	KIDNEY PROBLEMS	YES	NO
VENEREAL DISEASE	YES	NO	GLAUCOMA	YES	NO
LOW BLOOD PRESSURE	YES	NO	CANCER ______________________	YES	NO

DO YOU SMOKE? YES NO CIGARETTES ________ PIPE ________ CIGARS _________

HOW MANY/HOW OFTEN? ____

FOR WOMEN ONLY

ARE YOU TAKING FEMALE HORMONES (ORAL CONTRACEPTIVES, ETC.)? YES NO

ARE YOU PREGNANT OR BREAST FEEDING AT THE PRESENT TIME? YES NO

THE SUCCESS OF YOUR TREATMENT IS DEPENDENT UPON MANY FACTORS, INCLUDING THE SEVERITY OF THE PERIODONTAL DESTRUCTION, THE PATIENT'S GENERAL PHYSICAL STATUS, AND THE PATIENT'S ABILITY AND WILLINGNESS TO PERFORM PROPER ORAL HYGIENE AND STAY ON A RECALL PROGRAM AFTER ACTIVE TREATMENT. AS WITH TREATMENT OF ANY COMPLEX CONDITION, ESPECIALLY WHERE DRUGS AND SURGICAL PROCEDURES ARE BEING USED, UNUSUAL AND UNANTICIPATED COMPLICATIONS CAN OCCUR, SUCH AS BLEEDING, PROLONGED NUMBNESS, SENSITIVITY TO MEDICATIONS, SENSITIVE OR LOOSE TEETH, AND PULP DAMAGE. NATURALLY WE WILL MAKE EVERY EFFORT TO KEEP YOU INFORMED OF THE BEST TREATMENT FOR YOU. WE ALSO WELCOME YOUR QUESTIONS. YOUR INVOLVEMENT AND UNDERSTANDING ARE VERY IMPORTANT TO THE LONG-TERM SUCCESS OF YOUR TREATMENT.

IF THERE IS ANY FURTHER INFORMATION YOU FEEL WE SHOULD BE AWARE OF, PLEASE LIST HERE:

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*ACKNOWLEGEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, ______________________________, HAVE RECEIVED A COPY OF THIS OFFICE’S NOTICE OF PRIVACY PRACTICES.

____ _______________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME : ____ RELATIONSHIP: _____________________________

HOME PHONE: _________________________________ CELL PHONE: _________________________________

PATIENT OR GUARDIAN SIGNATURE: _____________________________________ DATE: _______________

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FOR FUTURE OFFICE USE:

I HAVE REVIEWED MY HEALTH HISTORY AND MARKED ANY CHANGES.

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SIGNATURE OF PATIENT/GUARDIAN DATE

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