KRK IMPLANT CENTER
PERIODONTICS & DENTAL IMPLANTS

PATIENT INFORMATION FORM

NAME: _____ BIRTHDATE: _____ AGE: _____
ADDRESS: _____ CITY: _____ STATE: _____ 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: _____

HOW WOULD YOU PREFER TO RECEIVE YOUR STATEMENTS?
MAIL _____ EMAIL _____ TEXT _____

IF YOU HAVE DENTAL INSURANCE, PLEASE GIVE YOUR CARD TO THE RECEPTIONIST. WE ARE HAPPY TO SUBMIT A CLAIM TO YOUR INSURANCE PROVIDER, AND THEY WILL REIMBURSE YOU.

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
SEIZURES 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
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:

_____

_____

___ DOCTOR KRUEGER REVIEWED THE MEDICAL AND DENTAL HISTORY DIRECTLY WITH THE PATIENT.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I I WILL NOT HOLD MYD ENTIST OR ANY OTHER MEMBER OF THE STAFF RESPOSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

PATIENT: _____ CLINICIAN: _____

*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: _____