Kruckman
FAMILY DENTISTRY

Adult Pre-Clinical History

Today's date: __________

ABOUT YOU

Name: ______________________ ❏ Female ❏ Male

Nickname: ______________________

Address: ______________________

City: ______________ State: ______ Zip: ________

Home phone: ______________ Bus. phone: ______________

Cell phone: ______________________

Birth date: ____/____/____ Marital status: ❏ Single ❏ Married ❏ Widowed

E-mail address: ______________________

Name of spouse: ______________________

Names of children: ______________________

Employer ______________ Occupation ______________

Who can we thank for referring you? ______________________

Referrals are our greatest compliment. As a thank you, they will receive a gift card

EMERGENCY INFORMATION

Person to contact: ______________________

Relationship: ______________ Phone: ______________

❏ I give permission for Kruckman Family Dentistry to share my medical and account information with:

____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance Company: ______________________

Address: ______________________

Phone: ______________________

Name of policy holder: ______________________

Relationship to policy holder: ❏ Self ❏ Spouse ❏ Child ❏ Other ______________

Policy holder's ID/social security #: ______________ Group #: ______________

Policy holder's birth date: ____/____/____

Policy holder's employer: ______________________

Name of Secondary Insurance Company: ______________________

Address: ______________________

Phone: ______________________

Name of policy holder: ______________________

Relationship to policy holder: ❏ Self ❏ Spouse ❏ Child ❏ Other ______________

Policy holder's ID/social security #: ______________ Group #: ______________

Policy holder's birth date: ____/____/____

Policy holder's employer: ______________________

MEDICAL HISTORY

Name of personal physician: ____

Address: ______________________________ Phone number: ______________

Approximate date of last visit:__________ Current health condition: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had any serious health problems in the last five years? ❑ yes ❑ no If yes, please explain: ______

____

(For women) Are your currently pregnant? ❑ yes ❑ no If yes, how many months? ______________

Please list prescription medications: ____________________________________

____

Please list vitamin/herbal supplements? ____________________________________

____

Do you know your blood pressure? ❑ yes ❑ no (If yes, what is it?) ____________________

Tobacco use? ❑ yes ❑ no

Please check if you're allergic to any of the following:

- ❑ Local anesthetics
- ❑ Penicillin/other antibiotics
- ❑ Barbiturates, sedatives, sleeping pills
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Shellfish, iodine or red wine
- ❑ Codeine/other narcotics
- ❑ Latex sensitivity
- ❑ Other______________

Do you have, or have you had, any of the following?

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:______________________

____

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: ________

The information I have given is true and accurate to the best of my knowledge.

Signature ______________________________ *Date* ______________

DENTAL HISTORY

On a scale of 1 to 5 (1 low/poor, 5 high/good) please rate:

How do you feel your overall dental health is:...1 2 3 4 5

Over the last ten years rate how faithfully have you had your teeth cleaned:...1 2 3 4 5

What is your level of sensitivity to dental procedures? 1 2 3 4 5

How do you feel about your smile and the look of your teeth: 1 2 3 4 5

Date of your last hygiene visit? _____/_____/_______

Are you interested in having regular hygiene cleanings? ❏ yes ❏ no

What is the main reason for your visit today?

❏ Tooth pain ❏ I need a check-up ❏ Cleaning

❏ Orthodontics (braces) ❏ Whitening ❏ Cosmetic dentistry

❏ Sedation dentistry ❏ Other ________________________________

Have you ever been treated for TMJ? ❏ yes ❏ no

Have you ever or do you suffer from headaches? ❏ yes ❏ no

Tension headaches? ❏ yes ❏ no Migraine headaches? ❏ yes ❏ no

Muscle tenderness in jaw/teeth? ❏ yes ❏ no

Do you need to take antibiotics prior to dental treatment? ❏ yes ❏ no

I would like to learn more about:

❏ Orthodontics ❏ Whitening ❏ Cosmetic dentistry ❏ Sedation dentistry

❏ Implants ❏ Bridges ❏ Veneers ❏ Dentures

❏ Other ____

I ____, agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Kruckman Family Dentistry. Initials:_________

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in a $50 charge and then discontinuation of services. Initials:________

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Consent for Use & Disclosure of Health Information

Section A: Patient Giving Consent

Name:____ Birth date: ____/____/____

Address:____

Section B: Please read the following statement carefully.

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and other important matters about your protected health information.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting:

Tammy at Kruckman Family Dentistry, 576 Cherry Dr., Waconia, MN 55387, 952-679-4461

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of revocation, submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Section C: Signature

I have had full opportunity to read and consider the contents of this Consent Form and Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my health information to carry out treatment, payment activities and health care operations.

X____

576 Cherry Dr., Waconia, MN 55387 • 952-679-4461 • Email: dentist@kruckmanfamilydentistry.com • www.KruckmanFamilyDentistry.com