Gordon E. Krueger DDS, MS, PA

Certified Prosthodontist

PERSONAL INFORMATION: DATE:_____

Patient Name:_____
Last First Middle

Date of Birth: ____/_____/_____ Sex: _____ Marital Status:_____

Address: _____
Street Apt/Unit/Lot #

_____
City State Zip

Home Phone: _____ Cell: _____Work:_____

Email Address:_____

Pharmacy Name/Location/Phone Number: _____

Emergency Contact: _____ Phone #: _____

Employer:_____Occupation:_____

GETTING TO KNOW YOU:

Whom may we thank for referring you? _____
Please describe your dental problem and or purpose of this visit: _____

_____
When was your last dental visit? _____
For what service? _____
When were your last dental x-rays taken? _____
Dr.'s Name: _____ Phone #: _____
Have you had any teeth removed, if so when? _____
Do you have "Dry Mouth"? _____
Do you clench grind your teeth? (day or night) _____

MEDICAL HISTORY:

How would you consider your health? Excellent Good Fair Poor

Personal Physician:_____
Physician Phone #: _____ Date of last visit: _____
Are you currently under a doctor's care, if so please explain? _____

Have you been hospitalized in the past 2 years or had any major surgeries? ☐ YES ☐ NO
If so, please explain:_____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

- ☐ Abnormal Bleeding
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Angina/ Chest Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Pressure
  - ☐ High
  - ☐ Low
- ☐ Blood Problems
- ☐ Breathing Issues
- ☐ Cancer
  - ☐ Chemotherapy
  - ☐ Radiation
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Gag Reflex
- ☐ Had COVID
  - ☐ Vaccination I
  - ☐ Vaccination 2
  - ☐ Booster
- ☐ Heart Artificial Valve
- ☐ Heart Attack(s)
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Stent
- ☐ Heart Surgery
- ☐ HIV/AIDS
- ☐ Hepatitis
  - ☐ Type A
  - ☐ Type B
  - ☐ Type C
- ☐ Irregular Heart
- ☐ Joint Replacement
- ☐ Kidney Trouble
- ☐ Lung Problems
- ☐ Mitral Valve Prolapse
- ☐ Nervousness
- ☐ Pregnant (Currently)
- ☐ Psychiatric Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Taking Blood Thinner
  - ☐ Baby Aspirin
  - ☐ Other
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Do you smoke?
  - ☐ Yes
  - ☐ No
- ☐ Weight in 1 year
  - ☐ Gained 10+
  - ☐ Lost 10+

Do you have any health conditions not listed above? If so, please explain:_____

_____

_____

Please list all medications you are currently taking, prescription or non-prescription:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic or have you had any ill effects from any particular drug, medications etc.?

☐ NO KNOWN ALLERGIES _____ _____

_____ _____ _____

Do you require any antibiotics before dental or medical treatment? (i.e. hip/knee/joint Replacement, Mitral Valve Prolapse, Rheumatic Fever, Heart Surgery or Heart Murmur)

☐ YES ☐ NO ☐ UNKNOWN

Are you currently taking any bone density/ Osteoporosis medications? ☐ YES ☐ NO

Are you currently taking any blood thinners? ☐ YES ☐ NO

FINANCES: (fees for services performed outside this office are the patient's responsibility)

Person responsible for Payment: _____

We require a 48-hour cancellation notice or a $55.00 fee will be charged.

I fully understand that Dr. Krueger cannot assume responsibility for pre-existing medical/dental complications. Age, health, adaptability, and attitude are major factors in dental health services. Thus, no guarantee or refund will be considered. There is no way of predicting the degree of success in prosthetic dentistry.

_____

Your Signature Date

INSURANCE:

We do not base our services on Insurance coverage. Insurance papers are filled out as a courtesy. You are responsible for any amount you're Insurance does not cover.

Dental Insurance Co.:_____ Phone #: _____

Insurance Address: _____

Member ID #: _____ Group #: _____

Employers Name: _____

Employee/Subscriber's Name: _____

Date of Birth: _____ Social Security #: _____

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment of Healthcare Operations, Per HIPAA Regulations

I understand that as part of my healthcare, the practice originates and maintains paper/electronic records describing my health history, symptoms examinations and test results, diagnosis, treatment and any plans for future care and treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services were rendered.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of staff.

I have been provided with a "Notice of Patient Privacy Practices" that provide a more complete description of information uses and disclosures. I understand that I have the right to review the "Notice" prior to acknowledging this consent, the right to restrict or revoke the use or disclosure of my health information for other uses or purposes, the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Patient Communication

By Law, without your authorization Dr. Gordon E. Krueger DDS, MS, PA cannot communicate with:

- Your spouse
- Your adult Children or Caregivers
- Your Parents (if you are over 18 years or over)

Dr. Gordon E. Krueger DDS, MS, PA does send out appointment reminders via email, text, and digital phone calls.

Dr. Gordon E. Krueger DDS, MS, PA may need to communicate with your family or caregivers in the following circumstances:

- Making appointments
- Confirming appointments
- Discussing treatment needed or performed
- Account, Insurance or Financial Information

Please print below the NAMES of people who we may communicate with regarding your appointment, medical/dental or account information.
If you DO NOT give permission to anyone LEAVE BLANK.

☐ My Spouse _____

☐ My Adult Children _____

☐ My Parents _____

☐ Other _____

Patient/Guardian Signature: _____ **Date:** _____

Print Name of Person Signing: _____

* If other than (Patient Name) _____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment, or healthcare operations? Yes ( ) No ( )