new patient information

harold a. krueger II, dds
oral and maxillofacial surgery

913.529.5999

PLEASE BE ADVISED THAT WE ARE NOT A MEDICARE/MEDICAID PROVIDER.
PLEASE TURN OFF YOUR CELL PHONE.

Date _____

Patient Name _____ Nickname _____
Last *First* *Middle Initial*

SSN #_____ DOB _____ Employer _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

Email _____

Referring Dentist _____ Medical Doctor _____

Closest Relative (Separate Residence) _____ Phone _____

Does the patient have any **insurance** to help pay for the appointment today? ❒ Yes ❒ No

Cardholder Name *(If Different From Patient)* _____

SSN #_____ DOB _____ Employer _____

Person Responsible for Paying the Account _____

Address _____ City _____ State _____ Zip _____

Phone _____ SSN #_____ Relationship _____

Is patient currently enrolled as a full time student? ❒ Yes ❒ No

School Name/Location _____ Graduation Date _____

If the patient is a minor child, the parent that accompanies the child to the office will be responsible for paying the account.

Please provide front and back copy of insurance card(s) OR complete the requested information on page 2.
IF THE PATIENT DOES NOT HAVE INSURANCE, FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

primary dental insurance information

Dental Insurance Company _____

Claims Mailing Address _____

Phone _____ Website _____

Cardholder Name _____

SSN # _____ DOB _____ Employer _____

ID# _____ Group # _____

secondary dental insurance information *(if any)*

Dental Insurance Company _____

Claims Mailing Address _____

Phone _____ Website _____

Cardholder Name _____

SSN # _____ DOB _____ Employer _____

ID # _____ Group # _____

medical insurance information

Medical Insurance Company _____

Claims Mailing Address _____

Phone _____ Website _____

Cardholder Name _____

SSN # _____ DOB _____ Employer _____

ID # _____ Group # _____

We will gladly file your insurance claim as a courtesy; please note any outstanding balance will become the patient's responsibility after 60 days.

PATIENT NAME _____ **HEIGHT**_____ **WEIGHT**_____ **AGE**_____

Are you allergic to any food, drug or other substance? yes ❒ no ❒
(i.e. nuts, soybeans, eggs, shellfish, sulfites or insect bites/stings, metals, or latex, etc.)

If so, what?_____

Have you been under the care of a physician during the last year? yes ❒ no ❒

If so, for what? _____

Are you taking any "bone density medication" (bisphosphonate)? yes ❒ no ❒
(i.e. fosamax, boniva, actonel, didronel, reclast, etc.)

Do you take this medication orally or intravenously? _____

How often do you take this medication?_____

How long have you been taking this medication?_____

Are you taking any other medication now? yes ❒ no ❒

If so, what? _____

Have you taken **any** kind of medicine during the past year?	yes ❒	no ❒
Have you ever had any bleeding requiring special treatment?	yes ❒	no ❒
Do you take any type of blood thinner, **including aspirin**?	yes ❒	no ❒
Do you take aspirin products more than twice a week?	yes ❒	no ❒
Do you take pre-medication for joint replacement or heart problems?	yes ❒	no ❒
Do you smoke or chew tobacco products?	yes ❒	no ❒

Have you ever been treated for or told you have any of the following? *(please circle)*

heart trouble	diabetes	kidney disease	cancer
heart murmur	recurrent cough	viral infections	dizziness or fainting
heart attack	hay fever	jaundice	alchoholism
irregular heartbeat	shortness of breath	epilepsy	chemical dependency
heart disease / any heart surgery	pneumonia	psychiatric treatment	asthma
rheumatic fever	tuberculosis	arthritis	**any other condition not listed?**
high blood pressure	anemia	osteoporosis	
stroke	hepatitis	hip / knee / joint replacement	
sinus trouble	liver disease	organ transplant	

Do you use a "CPAP" machine or similar for sleep apnea?	yes ❒	no ❒
Have you ever had a blood transfusion?	yes ❒	no ❒
Have you ever tested **positive** for HIV?	yes ❒	no ❒
Have you ever tested **positive** for hepatitis? If so, Type:_____	yes ❒	no ❒

Please name any major surgeries or illnesses current or past: _____

Please list the name & phone number of any physicians you see (especially specialists i.e. cardiologists, oncologists, etc.):

_____

_____

ANSWER THE BELOW QUESTIONS IF YOU ARE RECEIVING SEDATION OR GENERAL ANESTHESIA:

Have you received IV sedation or general anesthesia previously?	yes ❒	no ❒
Have you had anything to eat or drink within the past 6-8 hours?	yes ❒	no ❒
Are you wearing contact lenses?	yes ❒	no ❒
Are you wearing any removable dental appliances?	yes ❒	no ❒
(WOMEN) Are you pregnant?	yes ❒	no ❒
Have you had any reaction to any anesthetic agent in the past?	yes ❒	no ❒

SIGNATURE _____ **DATE** _____