

******Please turn off your cell phone******

**PLEASE BE ADVISED THAT WE ARE NOT A
MEDICARE/MEDICAID PROVIDER**

Harold A. Krueger II, D.D.S.

Oral and Maxillofacial Surgery
Confidential Patient Information

Date _____

Patient's Name _____
(Last) (First) (Initial) (Nickname)

Soc. Sec# _____ Date of Birth _____

Address Street _____ Home Phone _____

City _____ Business Phone _____

State _____ Zip _____ Employer _____

Email Address: _____

Referring Dentist _____ Medical Doctor _____

Closest Relative, *not living with you* _____ Phone _____

Does the patient have any **Private Insurance** to help pay for the appointment today? **Yes** **No**

Cardholder's (if different than patient): Name: _____

SS# _____ Date of Birth _____

Employer _____

Please provide front and back copy of insurance card(s) **OR** complete the requested information on following page.

******If the patient does not have insurance, full payment is expected at the time of surgery. ******

Person responsible for paying the account* _____

Address _____

Phone# _____ Relationship _____ SS# _____

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

School Name and 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.**

Patient's Name _____ Date _____

Height _____ Weight _____ Age _____

Are you **allergic** to any food, drug or other substance (including nuts, soybeans, eggs, shellfish, sulfites or insect bites/stings, metals, latex?) YES NO

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
(e.g. 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? _____

For what condition(s)? _____

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 | Shortness of breath | Arthritis |
| Heart Murmur | Pneumonia | Osteoporosis |
| Heart Attack | Tuberculosis | Hip, Knee or any joint replacement |
| Irregular Heartbeat | Anemia | Organ Transplant |
| Heart Disease or any Heart Surgery | Hepatitis | Cancer (any type) |
| Rheumatic fever | Liver Disease | Dizziness or Fainting |
| High Blood Pressure | Kidney Disease | Alcoholism |
| Stroke | Viral Infections | Chemical Dependency |
| Sinus Trouble | Jaundice | Allergic reaction to <u>any</u> medication |
| Asthma | Diabetes | Food Allergies |
| Recurrent Cough | Epilepsy | Any other condition not listed |
| Hay Fever | Psychiatric Treatment | |

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 B or C-virus? YES NO

Please name any major surgeries or illnesses current or past:

Please list the name and phone number of any physicians you see (especially specialists such as 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 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 _____

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

Primary Dental Insurance Information

Dental Insurance Company Name _____

Claims mailing address _____

Insurance Company phone # _____

Website _____

Name of Cardholder _____

Cardholder's Social Security # _____

Cardholder's date of birth _____

Cardholder's employer _____

ID# _____

Group# _____

Secondary Dental Insurance Information-(if any)

Dental Insurance Company Name _____

Claims mailing address _____

Insurance Company phone # _____

Website _____

Name of Cardholder _____

Cardholder's Social Security # _____

Cardholder's date of birth _____

Cardholder's employer _____

ID# _____

Group# _____

Medical Insurance Information

Medical Insurance Company Name _____

Claims mailing address _____

Insurance Company phone # _____

Website _____

Name of Cardholder _____

Cardholder's Social Security # _____

Cardholder's date of birth _____

Cardholder's employer _____

ID# _____

Group# _____