

# Welcome to Krug Orthodontics!!!

**New Patient Information for:**

**Preferred Name:**

<b>Home Phone:</b> <input style="width: 90%;" type="text"/>	<b>Address:</b> <input style="width: 90%;" type="text"/>
<b>Work Phone:</b> <input style="width: 90%;" type="text"/>	
<b>Cell Phone:</b> <input style="width: 90%;" type="text"/>	<b>Email:</b> <input style="width: 90%;" type="text"/>
<b>Middle Name:</b> <input style="width: 80%;" type="text"/>	<b>Title:</b> <input style="width: 80%;" type="text"/>
<b>Soc Sec #:</b> <input style="width: 90%;" type="text"/>	
<b>Date of Birth:</b> <input style="width: 80%;" type="text"/>	<b>Sex:</b> <input type="checkbox"/> male <input type="checkbox"/> female
<b>School:</b> <input style="width: 90%;" type="text"/>	
<b>General Dentist:</b> <input style="width: 90%;" type="text"/>	<b>Date of Last Dental Visit:</b> <input style="width: 90%;" type="text"/>

**Primary Responsible Party Name:**

<b>Home Phone:</b> <input style="width: 90%;" type="text"/>	<b>Address:</b> <input style="width: 90%;" type="text"/>
<b>Work Phone:</b> <input style="width: 90%;" type="text"/>	
<b>Cell Phone:</b> <input style="width: 90%;" type="text"/>	<b>Email:</b> <input style="width: 90%;" type="text"/>
<b>Date of Birth:</b> <input style="width: 80%;" type="text"/>	<b>Title:</b> <input style="width: 80%;" type="text"/>
<b>Sex:</b> <input type="checkbox"/> male <input type="checkbox"/> female	<b>Soc Sec #:</b> <input style="width: 90%;" type="text"/>
<b>Relationship to Patient:</b> <input style="width: 90%;" type="text"/>	
<b>Employer:</b> <input style="width: 90%;" type="text"/>	

**Secondary Responsible Party Name:**

<b>Home Phone:</b> <input style="width: 90%;" type="text"/>	<b>Address:</b> <input style="width: 90%;" type="text"/>
<b>Work Phone:</b> <input style="width: 90%;" type="text"/>	
<b>Cell Phone:</b> <input style="width: 90%;" type="text"/>	<b>Email:</b> <input style="width: 90%;" type="text"/>
<b>Date of Birth:</b> <input style="width: 80%;" type="text"/>	<b>Title:</b> <input style="width: 80%;" type="text"/>
<b>Sex:</b> <input type="checkbox"/> male <input type="checkbox"/> female	<b>Soc Sec #:</b> <input style="width: 90%;" type="text"/>
<b>Relationship to Patient:</b> <input style="width: 90%;" type="text"/>	
<b>Employer:</b> <input style="width: 90%;" type="text"/>	

## Insurance Information

Primary Insurance Company	Secondary Insurance Company
<b>Name:</b> <input style="width: 90%;" type="text"/>	<b>Name:</b> <input style="width: 90%;" type="text"/>
<b>Policy holder:</b> <input style="width: 90%;" type="text"/>	<b>Policy holder:</b> <input style="width: 90%;" type="text"/>
<b>Phone Number:</b> <input style="width: 90%;" type="text"/>	<b>Phone Number:</b> <input style="width: 90%;" type="text"/>
<b>Address:</b> <input style="width: 90%;" type="text"/>	<b>Address:</b> <input style="width: 90%;" type="text"/>
<b>Policy #:</b> <input style="width: 90%;" type="text"/>	<b>Policy #:</b> <input style="width: 90%;" type="text"/>

Name:

**Please check any of the medical conditions below that you have had or currently have**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Respiratory Treatment |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Rheumatism            |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Blood Thinner Use | <input type="checkbox"/> Growths            | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Stomach Problems      |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Hay Fever          | <input type="checkbox"/> Mental Disorder     | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Nervous Disorder    | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Tumors                |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers                |

Latex Allergy      Any other allergies:

- Do you currently, or have you ever taken bisphosphonate medication (for example Fosamax)?  yes  no
- Are you currently taking any other medications or vitamins?  yes  no  
If yes, please explain:
- Have you ever had any complications following dental treatment?  yes  no  
If yes, please explain:
- Have you been admitted to a hospital or needed emergency care in the last two years?  yes  no  
If yes, please explain:
- Are you currently under care of a physician?  yes  no  
If yes, please explain:
- Do you have any other health problems?  yes  no  
If yes, please explain:

- Do you have a thumb or finger sucking habit?  yes  no
- Have you ever been treated with orthodontics before?  yes  no
- Have you ever had trouble associated with previous treatment?  yes  no
- Are you unhappy with the appearance of your teeth?  yes  no
- Have you ever been told that you grind your teeth?  yes  no
- Are you aware that you are clenching your teeth during the day?  yes  no
- Are you aware of jaw clicking or popping?  yes  no
- Do you get frequent headaches, earaches, or have joint pain?  yes  no
- Have you ever experienced ringing in your ears?  yes  no
- Are you a mouth breather?  yes  no
- Are you aware that some of your appointments will be during work/school hours?  yes  no

If the patient is under the age of 16, what is the height of the parent?    Mother     Father

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my (or my child's) health, I will inform Dr. Krug at my next appointment.

**Benefits of Orthodontics:** Esthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. In addition, I authorize Dr. Krug to perform a complete orthodontic evaluation and have the needed orthodontic records (diagnostic photographs, x-rays, and dental impressions) taken. I authorize Krug Orthodontics to file and collect insurance payment for services rendered. I authorize the transmission of my orthodontic records including x-rays, photographs and models in electronic formats including non-encrypted electronic mail.

**Notice of Privacy Practices:** You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment, activities, and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician, or other healthcare provider providing you treatment to you. We may use your photos and records for demonstration or publication purposes. Patient Rights: You have a right to look at or get copies of your health information with limited exceptions. I grant my permission to Krug Orthodontics or its assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content. I have read and understand the above

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_