Welcome to Krug Orthodontics!!!

New Patient Information for:

Preferred Name:

Home Phone:		**Address:**	
Work Phone:			
Cell Phone:		**Email:**	
Middle Name	**Title**	**Soc Sec #:**	
Date of Birth:	**Sex:** ☐ male ☐ female	**School:**	
General Dentist:		**Date of Last Dental Visit:**	

Primary Responsible Party Name:

Home Phone:		**Address:**	
Work Phone:			
Cell Phone:		**Email:**	
Date of Birth:	**Title:** **Sex:**	**Soc Sec #:**	
Relationship to Patient:			
Employer:			

Secondary Responsible Party Name:

Home Phone:		**Address:**	
Work Phone:			
Cell Phone:		**Email:**	
Date of Birth:	**Title:** **Sex:**	**Soc Sec #:**	
Relationship to Patient:			
Employer:			

Insurance Information

Primary Insurance Company		**Secondary Insurance Company**	
Name:		**Name:**	
Policy holder:		**Policy holder:**	
Phone Number:		**Phone Number:**	
Address:		**Address:**	
Policy #:		**Policy #:**	

Name: _____

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

☐ AIDS	☐ Epilepsy	☐ Hepatitis	☐ Respiratory Treatment
☐ Anemia	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Fainting	☐ Jaundice	☐ Rheumatism
☐ Artificial Joints	☐ Glaucoma	☐ Kidney Disease	☐ Sinus Problems
☐ Blood Thinner Use	☐ Growths	☐ Liver Disease	☐ Stomach Problems
☐ Blood Disease	☐ Hay Fever	☐ Mental Disorder	☐ Stroke
☐ Cancer	☐ Head Injury	☐ Nervous Disorder	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Pacemaker	☐ Tumors
☐ Dizziness	☐ Heart Murmur	☐ Radiation Treatment	☐ 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

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of Patient, Parent, or Guardian