

# MEDICAL HISTORY UPDATE

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

How would you prefer to receive appointment reminders: Text Email Call (circle one)

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

How would you consider your health? Excellent Good Fair Poor (circle one)

Personal Physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under a Doctor's care, If so please explain? \_\_\_\_\_

Have you been hospitalized or had any surgeries in the past 2 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES please explain: \_\_\_\_\_

## DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

**\* (Please Circle)\***

Abnormal Bleeding	Fainting/ Dizziness	Psychiatric Treatment
Alcoholism	Gag Reflex	Radiation
Allergies	Heart Attack(s)	Rheumatic Fever
Anemia	Heart Murmur	Sinus Problems
Angina/Chest Pain	Heart Pacemaker	Stroke
Arthritis	Heart Surgery	Taking Blood Thinners
Artificial Heart Valve	Hepatitis	Thyroid Disease
Asthma	High Blood Pressure	Tuberculosis
Blood Problems	HIV/ AIDS	Do you smoke:
Breathing Problems	Joint/Hip Replacement	yes or no
Cancer	Kidney Trouble	Gained/ Lost 10 lbs
Chemotherapy	Low Blood Pressure	in the last year
Diabetes	Lung Problems	<b>IF FEMALE:</b>
Epilepsy	Mitral Valve Prolapse	Had Hysterectomy
Irregular Heart/Murmur	Nervousness	Currently Pregnant

Do you have any health conditions not listed above? If so please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone Number

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, medication, etc.?  
\_\_\_\_\_

Do you require any antibiotic before dental or medical treatment? (i.e. hip/knee/joint replacement, Mitral Valve Prolapse, Rheumatic Fever, Heart Surgery or Heart Murmur)  
Yes \_\_\_\_\_ No \_\_\_\_\_

## INSURANCE

NEW insurance: please have your card ready so we may make a copy for our records.  
*We do not base our services on Insurance coverage; Insurance papers are filled out as a courtesy*

<b>IF THIS INFORMATION IS THE <u>SAME</u> YOU DO NOT NEED TO FILL OUT</b>	
Dental Insurance Co.: _____	Phone #: _____
Insurance Address: _____	
Member ID #: _____	Group #: _____
Employers Name: _____	
Employee/ Subscriber's Name: _____	
Date of Birth: _____	Social Security #: _____

***You will be responsible for any amounts not covered by insurance.***

*I fully understand that Dr. Krueger cannot assume responsibility for per-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.*

**We require a 48 hour cancellation notice or a**

\_\_\_\_\_  
Your Signature Date

*Gordon E. Krueger DDS, MS, PA*  
*Certified Prosthodontist*

**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 actually 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 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 indicate below the names of people who we may communicate with regarding your appointment, medical/dental or account information:**

- 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 ( )