Daniel A. Kruse, D.D.S., M.S.D. SPECIALIST IN ORTHODONTICS

Patient Information Date Completed ____/____/____

Patient's Name _____ Preferred Name _____
Last First M.I.

☐ M ☐ F Birthdate ____/____/____Age _____ Patient's School _____ Grade _____

Street Address_____ City_____ State _____ Zipcode _____

Phone (_____) _____ Email _____ Cell Phone (_____)_____

Hobbies & Interests _____

General Dentist _____Date of last visit_____ Whom may we thank for referring you? _____

Name & Age of Siblings_____

Emergency Contact

Name _____ Relationship _____

Street Address_____ City_____ State _____ Zipcode _____

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

Responsible Party Information

Name _____ Marital Status _____
Last First M.I.

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian Social Security # _____ Birthdate ____/____/____

Street Address_____ City_____ State _____ Zipcode _____

Phone (_____) _____ Email _____ Cell Phone (_____)_____

Employer _____ Occupation _____ Work Phone (_____)_____

Spouse's Name _____ Marital Status _____
Last First M.I.

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian Social Security # _____ Birthdate ____/____/____

Street Address_____ City_____ State _____ Zipcode _____

Phone (_____) _____ Email _____ Cell Phone (_____)_____

Employer _____ Occupation _____ Work Phone (_____)_____

Dental / Orthodontic Insurance Information

Primary Insured's Name _____ Social Security # _____
Last First M.I.

Address if different than patient _____

Insurance Co._____

Group # _____ Member ID# _____ Birthdate ____/____/____

Insurance Co. Address _____ Phone (_____)_____

Insured's Employer_____Do you have dual coverage? ☐ Yes ☐ No *If "Yes" complete below:*

Secondary Insured's Name _____ Social Security # _____
Last First M.I.

Address if different than patient _____

Insurance Co._____

Group # _____ Member ID# _____ Birthdate ____/____/____

Insurance Co. Address _____ Phone (_____)_____

Insured's Employer_____

Dental & Medical History

What are the main concerns that you would like orthodontics to accomplish?

Do you like your smile? If not, what would you change?

Has patient ever been evaluated or had orthodontic treatment before? ..... ❑ Y ❑ N

Any injuries to face, mouth or chin? ..... ❑ Y ❑ N

Are antibiotics required before dental treatment? ..... ❑ Y ❑ N

Have adenoids or tonsils been removed? ..... ❑ Y ❑ N

Any missing or extra permanent teeth? ..... ❑ Y ❑ N

Any pain/tenderness in jaw joint (TMD/TMJ)? ..... ❑ Y ❑ N

Any of the following habits? Y/N

Clenching/grinding teeth	Y N	Lip sucking/biting	Y N
Mouth breather	Y N	Nail biting	Y N
Nursing/bottle habits	Y N	Tongue thrust	Y N
Thumb/finger sucking	Y N	Pacifier usage	Y N
Smoking/tobacco use	Y N	Floss daily	Y N
Brush teeth daily	Y N		

Is patient allergic to any of the following? Y/N

Aspirin	Y N	Latex	Y N
Codine	Y N	Penicillin	Y N
Dental Anesthetics	Y N	Tetracycline	Y N
Erythromycin	Y N	Other	Y N
Jewelry/Metals	Y N	*If other please list below*	

Other Drug/Material Allergies: _____

Is patient taking prescription/over-the counter drugs? ..... ❑ Y ❑ N

Please list each drug: _____

Has patient taken Phen-Fen (Redux or Pondimin)? ..... ❑ Y ❑ N

If so, when?: _____

Women: Are you taking birth control pills? ..... ❑ Y ❑ N

Women: Are you pregnant? If so, week # _____ ..... ❑ Y ❑ N

Current Physical Health ❑ Good ❑ Fair ❑ Poor

Physician's Name: _____

Phone (_____) _____ Date of last visit _____

Please list any serious medical condition(s):

Has patient had any of the following? Y/N

Abnormal bleeding/Hemophilia	Y N	Herpes/Fever Blisters	Y N
ADD/ADHD	Y N	High Blood Pressure	Y N
AIDS	Y N	HIV	Y N
Alcohol/Drug Abuse	Y N	Hospitalized - for any reason	Y N
Anemia	Y N	Kidney Problems	Y N
Arthritis	Y N	Liver Disease	Y N
Artificial bones/joints/valves	Y N	Low Blood Pressure	Y N
Asthma	Y N	Lupus	Y N
Blood Transfusion	Y N	Mitral Valve Prolapse	Y N
Cancer/Chemotherapy	Y N	Pacemaker	Y N
Colitis	Y N	Psychiatric Problems	Y N
Congenital Heart Defect	Y N	Radiation Treatment	Y N
Diabetes	Y N	Rheumatic/Scarlet Fever	Y N
Difficulty Breathing	Y N	Seizures	Y N
Emphysema	Y N	Shingles	Y N
Epilepsy	Y N	Sickle Cell Disease/traits	Y N
Fainting Spells	Y N	Sinus Problems	Y N
Frequent Headaches	Y N	Stroke	Y N
Glaucoma	Y N	Thyroid Problems	Y N
Hay Fever	Y N	Tuberculosis (TB)	Y N
Heart Attack/Surgery	Y N	Ulcers	Y N
Heart Murmur	Y N	Venereal Disease	Y N
Hepatitis	Y N		

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature _____ Date: _____

For Office Use Only - Doctor's Comments: _____

_____

_____

_____

I have verbally reviewed the medical/dental information above with the parent/guardian named within.

Doctor's Signature _____ Date: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Dental & Medical History Updates

Has there been any change in your health status since your last visit? ..... ❑ Y ❑ N

If yes, please explain: _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

Has there been any change in your health status since your last visit? ..... ❑ Y ❑ N

If yes, please explain: _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____