David L. Krese, D.D.S.

Patient Information

Patient Name: _____ Date: _____
Last First Middle Initial

Preferred Name:_____ Gender:_____ Family Status:_____

Social Security **or** Drivers License #: _____ Birth Date: _____

Phone (Home): _____ (Work):_____ Ext. (Cell):_____E-mail:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ HIV/AIDS
- ☐ Congenital Heart Defect
- ☐ Steroid Treatments
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ G.E.R.D.
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ High Blood Pressure
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
  Are you nursing? ☐Y ☐N
  Taking Birth Control?
  ☐Y ☐N
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Wears contact lenses
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Chemotherapy
- ☐ Special Diet
- ☐ Shortness of Breath
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐Other_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Medications: SEE LIST ☐

Please list medications you are currently taking.

Low dose daily Aspirin: ☐ Yes ☐ No

_____
_____
_____
_____

Allergies

☐ Latex ☐ Sulfa ☐ Aspirin ☐ Codeine

☐ Penicillin ☐ Barbiturates ☐ Iodine ☐ Local Anesthetic

☐ Other_____

_____

Do you need to premedicate with antibiotics prior to dental appointments? ☐ Yes ☐ No

If yes, what medication do you take? _____

Emergency Contact Information

Name: _____ Phone: _____
Last First Middle Initial ☐ Home ☐ Cell ☐ Work

☐ Male ☐ Female

Relationship: ☐ Spouse ☐ Family Member ☐ Other: _____

***PLEASE COMPLETE BACK OF FORM - (SIGNATURES REQUIRED)* ➔**

Dental History

General Dentist_____ Reason for today's visit_____

Date of last dental visit? _____

Please check the following that applies to you:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips/mouth
- ☐ Burning sensation on tongue
- ☐ Chewing on side of mouth
- ☐ Cigarette or pipe smoking
- ☐ Jaw popping
- ☐ Dry Mouth
- ☐ Fingernail biting
- ☐ Grinding teeth
- ☐ Swollen or tender gums
- ☐ Lip or cheek biting
- ☐ Mouth breathing
- ☐ Loose teeth or broken fillings
- ☐ Mouth pain when brushing
- ☐ Orthodontic Treatment
- ☐ Pain around ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Snoring
- ☐ Anxiety prior to dental visits

What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft ☐ Electric

Do you use any of the following? - check all that apply:

☐ Toothpicks ☐ Water Pik ☐ Interdental brush ☐ Floss

How often do you floss?_____

How often do you brush?_____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

SEE COPY OF INSURANCE CARD ☐

Name of Subscriber: _____

Last First MI

Subscriber's Birth Date: _____ Subscriber ID #: _____ Group #: _____

Insurance Plan Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

ACKNOWLEDGEMENT OF RECEPIT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices and have completed the HIPAA compliant record request form. I understand that by signing these forms, I grant the office of *David L Krese, D.D.S.* permission to obtain my medical and/or dental records. I understand that all personal information submitted is confidential and will only be used for necessary medical and/or dental purpose(s).

X_____ Date_____

Signature of patient, parent or guardian

NOTICE OF DEEMED CONSENT TO HIV/HEPATITIS BLOOD TESTING

A law, enacted in Virginia in 1989, authorized health care workers to test their patients for HIV antibodies if they are exposed to the body/blood fluids of a patient in a manner that may transmit human immunodeficiency virus (HIV) or Hepatitis. These tests, and their results, like all medical/dental information, will be treated as confidential. Patients will not be discriminated against or denied dental care on the basis of a positive Hepatitis or HIV test.

x_____ x_____Date: _____

Signature of patient, parent or guardian Signature of Witness