

# ABOUT YOU

You are very important to us. We would really appreciate it if you would be so kind as to take the time to enlighten us with a few answers to the following questions so that we may better serve you.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Last First MI

I prefer to be called: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_  Male  Female

Mailing Address: \_\_\_\_\_  
City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State Zip

Status:  Minor  Single  Married  Divorced  Widowed Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_ Children's Names/Ages: \_\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #1: (\_\_\_\_) \_\_\_\_\_ Phone #2: (\_\_\_\_) \_\_\_\_\_

Account Information: Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Payment method:  Cash  Check  Credit Card \_\_\_\_\_  
Card # Exp. Date Sec. Code

\_\_\_\_\_  
Initials I hereby authorize my card to be charged for services rendered on my behalf by Kremer Dental Care, Kevin Kremer, D.D.S., Inc., and its representatives.

Insurance Information: Co. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's ID#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

\_\_\_\_\_  
Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

❖ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.  
❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office administrator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  
❖ I authorize Dr. Kremer and his team to perform any necessary services needed during diagnosis and treatment. I also authorize Dr. Kremer to release any information required to process insurance claims.  
❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Adult Patient  Parent or Guardian  Spouse

(Please complete both sides)

# HEALTH & DENTAL HISTORY

Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you been under the care of a medical doctor during the past two years?  
If so, for what? \_\_\_\_\_

Yes  No

Are you taking any medication now, including regular dosages of aspirin?  
If so, please list the *name, dosage, and frequency taken* \_\_\_\_\_

Yes  No

**Indicate which of the following you have had, or have at present. Circle "Y" for yes or "N" for no to each item.**

AIDS/HIV+/ARC	Y	N	Glaucoma	Y	N	Neurological Disorders	Y	N
Alcohol/Drug Abuse	Y	N	Headaches	Y	N	Psychiatric/Psychological	Y	N
Anemia	Y	N	Heart Surgery/Pacemaker	Y	N	Radiation/Chemotherapy	Y	N
Artificial Joints	Y	N	Heart Attack	Y	N	Respiratory Problems	Y	N
Artificial Heart Valves	Y	N	Heart Murmur/A-Fib	Y	N	Rheumatic Fever	Y	N
Arthritis/Rheumatism	Y	N	Hepatitis	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	High/Low Blood Pressure	Y	N	Sinus Problems	Y	N
Back Problems	Y	N	Heart Disease	Y	N	Sensitive Teeth	Y	N
Bell's Palsy	Y	N	Insomnia	Y	N	Stomach Problems/Ulcers	Y	N
Bleeding Problems	Y	N	Jaw Problems TMJ/TMD	Y	N	Stroke	Y	N
Cancers/Tumors	Y	N	Kidney Problems	Y	N	Thyroid Problems	Y	N
Chest Pains	Y	N	Leukemia	Y	N	Tuberculosis TB	Y	N
Cosmetic Surgery	Y	N	Liver Disease/Jaundice	Y	N	Venereal Disease	Y	N
Diabetes/Hypoglycemia	Y	N	Mitral Valve Prolapse	Y	N	Xray or Cobalt Treatment	Y	N
Emphysema	Y	N	Neck Pain	Y	N			
Facial Pain	Y	N	Nervousness	Y	N			

Do you have or have you had any disease, condition or surgery not listed?  
If yes, please describe \_\_\_\_\_

Yes  No

**Do you have any of the following allergies?**  Latex  Penicillin/Amoxicillin  Tetracycline  Aspirin  Seasonal  
 Dental Anesthetics  Others: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone#

Do you require pre-medication? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you clench or grind your teeth? <input type="checkbox"/> No <input type="checkbox"/> Yes
Does floss shred when you use it? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you snore or have sleep apnea? <input type="checkbox"/> No <input type="checkbox"/> Yes
Does food pack or catch between your teeth? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does your bite feel uncomfortable? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you see a chiropractor? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do your jaw joints click or pop? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do your gums bleed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your breath concern you? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you use tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes/How used? _____ How much? _____ How long? _____	
Times a day you brush? _____ Times a week you floss? _____	
Last Dental Exam: ____/____/____ Last Dental X-rays: ____/____/____ Last Teeth Cleaning: ____/____/____	
What type of tooth brush do you use? <input type="checkbox"/> Electric <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard	
Do you wear contact lenses? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Women</b> —Are you: Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Nursing? <input type="checkbox"/> No <input type="checkbox"/> Yes Taking birth control pills? <input type="checkbox"/> No <input type="checkbox"/> Yes	

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*

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

**Remember to fax these back to our office at 530-892-1272 two days prior to your visit, or mail them to our office in the enclosed envelope.**

<b>Updated:</b>	<b>Reviewed By:</b>		
Int. _____ Date _____	Int. _____ Date _____	Int. _____ Date _____	Int. _____ Date _____
Int. _____ Date _____	Int. _____ Date _____	Int. _____ Date _____	Int. _____ Date _____