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

_____ 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.
Initials

Insurance Information: Co. Name: _____ Address: _____

Insured's Name: _____ Insured's ID#: _____

Relationship to Patient: _____ Insured's Date of Birth: _____/_____/_____

Phone #: (____) _____ Group #: _____ Insured's Employer: _____

_____ 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.
Initials

❖ 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? ☐ Yes ☐ No
If so, for what? _____

Are you taking any medication now, including regular dosages of aspirin? ☐ Yes ☐ No
If so, please list the *name*, *dosage*, and *frequency taken* _____

_____

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? ☐ Yes ☐ No
If yes, please describe _____

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? ☐ No ☐ Yes
Does floss shred when you use it? ☐ No ☐ Yes
Does food pack or catch between your teeth? ☐ No ☐ Yes
Do you see a chiropractor? ☐ No ☐ Yes
Do your gums bleed? ☐ No ☐ Yes
Does your breath concern you? ☐ No ☐ Yes
Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How long? _____
Do you clench or grind your teeth? ☐ No ☐ Yes
Do you snore or have sleep apnea? ☐ No ☐ Yes
Does your bite feel uncomfortable? ☐ No ☐ Yes
Do your jaw joints click or pop? ☐ No ☐ Yes

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? ☐ Electric ☐ Soft ☐ Medium ☐ Hard
Do you wear contact lenses? ☐ No ☐ Yes
Women—Are you: Pregnant? ☐ No ☐ Yes Nursing? ☐ No ☐ Yes Taking birth control pills? ☐ No ☐ 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.

Updated:		**Reviewed By:**	
Int._____ **Date**_____	**Int.**_____ **Date**_____	**Int.**_____ **Date**_____	**Int.**_____ **Date**_____
Int._____ **Date**_____	**Int.**_____ **Date**_____	**Int.**_____ **Date**_____	**Int.**_____ **Date**_____