PATIENT MEDICAL HISTORY

Patient's Name:

,

For Office Use Only
ID: 785401

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:
,	

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:
(718) -	(718) - x	(718) -			Unknown

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex: Unknown

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP: / Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	HIV+ AIDS
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Stephen R. Kruger D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security # _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of out Notice, at any time by contacting:

Contact Person: Lily
Telephone: 718- 279-9190 Fax: 718- 631-7991
Address: 209-44 35th Ave Bayside, NY 11361

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Stephen Kruger, DDS

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. However, due to evolution and merges in the insurance industry we are not a member of all insurance plans. Therefore, it is the responsibility of the patient/ insured to confirm the individual dentist's participation and status with particular insurance plan.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to know all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services be performed.

Even with the same insurance company the plans differ depending upon what type of contract you employer has negotiated.

Providing quality dental care for our patients is our primary concern; we are more then willing to provide that care within your insurance contract guidelines if you let us know at each time of service what those guidelines are.

It is your responsibility as the patient/ insured, to be aware of the current terms of your insurance coverage. All copays, by contract, must be, paid, at the time of the visit. If your yearly deductible has not been met, this must be paid at the time of your visit. If you do not have insurance, or insurance we do not participate with, payment is expected at the time of service at our full price. For your convenience we accept cash, check, Visa MasterCard, American Express or Discover.

If services are provided and your coverage is not in effect, the fees submitted and denied by your carrier will become your responsibility, along with any fees incurred during collection.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and will be able to concentrate on caring for your dental needs.

I have read and understood the office policy stated above and agree to accept responsibility as described.

Patient and / or insured

Date

Stephen Kruger, DDS

Cancellation Policy

We understand that unplanned issues may come up and you may need to cancel or reschedule an appointment. However, when a patient does not show up for their scheduled appointment, another patient loses an opportunity to be seen.

If you need to cancel or reschedule an appointment, our cancellation policy requires 24 hours advance notice from your scheduled appointment time.

We respectfully ask that you call us at least 24 hours prior to your appointment, otherwise you will be responsible for a cancellation fee of $50.00 which will not be covered by your insurance company and is due at your next visit.

Thank you for being a valued patient and for your understanding and cooperation.

_____ _____

Signature Date