David L. Krese, D.D.S.
Practice Limited to Periodontics & Implantology

Patient Information

Patient's Name_____ Nickname_____ Gender_____
Birthday _____ SS# or Drivers License _____
Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ City _____ State_____ Zip_____

E-Mail _____ Emergency Contact and Phone _____

Health Information (check the ones that apply)

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ G.E.R.D.
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A ☐ B ☐ C ☐
- ☐ High Blood Pressure
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pregnant? Due date _____
- ☐ Are you nursing?
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Wear contact lenses
- ☐ 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 under the care of a physician? ☐ Yes ☐ No If yes, please explain _____
_____

Name of Physician _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain below
_____

Medications (all medications you are currently taking) **Low dose daily aspirin** ☐ Yes ☐ No **See List** ☐

_____

_____

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? _____

Dental History

Patient's Dentist _____ Last Visit? _____

Reason for today's visit? _____

(check the following that applies to you)

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

Insurance Information

Insured Full Name _____Birthday _____Relation to Patient _____

Insured Employer _____ Insurance Company Name _____

Insurance ID # _____ Group # _____

Insurance Address _____

ACKNOWLEDGEMENT OF RECEIPIT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Patient's Name (please print) _____

Patient's Signature _____ Date _____

NOTICE OF DEEMED CONSENT TO HIV/HEPATITIIS BLOOD TESTING

A law, enacted in Virginia in 1989, authorized health care workers to test their patients for HIV antibodies in the event they are exposed to the body/blood fluids of a patient in a manner that may transmit human immunodeficiency virus (HIV), hepatitis or any other communicable disease. We will only test if it is necessary. These tests and 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 their health history.

Signature _____ Witness _____ Date _____

(patient, parent or guardian)