Welcome to Our Office!

Collin D. Kraus DDS MS

Patient Information

Date_____

First name_____ **Last name**_____

Nick name_____ Other family members seen by us_____

DOB_____ M / F

Whom may we thank for referring you to our office_____

Responsible Party Information

Responsible Party's Name_____Relationship to patient _____

Mother/Guardian Name_____ Birth date____/____/_____

Mailing Address_____City_____State_____Zip _____

Home Ph.____-____-___ Cell Ph.____-____-____ SS#_____-_____ -_____ DL# _____

Employer _____ Occupation_____ No. yrs_____

Father/Guardian Name_____ Birth date____/____/_____

Mailing Address_____City_____State_____Zip _____

Home Ph.____-____-____Cell Ph.____-____-____ SS#_____-_____ -_____ DL# _____

Employer_____ Occupation_____ No. yrs_____

Parents are: Married _____ Divorced _____ Separated _____

If parents do not live together, who does the patient live with? _____

Dental Insurance Information

Insured's Name _____ Birth date____/____/____ Insured's SS #_____-_____-_____

Insurance Company_____Policy # _____Group #_____

Insurance Company address _____

Insurance Company Phone #____-____-_____ Insured's Employer_____

Secondary Insured's Name_____ Birth Date _____/_____/_____

Insured's SS #_____-_____-_____ Insurance Company_____

Policy #_____ Group #_____ Insurance Phone # _____

Secondary Insured's Employer_____

Secondary Insurance Company Address_____

Emergency Information

Emergency Contact (other than guardian)_____

Relationship_____Daytime Ph.____-____-_____Alternative Ph.____-____-_____

Collin D. Kraus DDS MS
Orthodontic Specialist - Board Certified

Health History

Patient Name: _____ Date: _____

Medical History

Please Check Yes or No if the patient has or has ever had...

Y	N	
[ ]	[ ]	Joint swelling or Arthritis
[ ]	[ ]	Bone Disorders
[ ]	[ ]	Heart Problems
[ ]	[ ]	Diabetes
[ ]	[ ]	High Blood Pressure
[ ]	[ ]	Thyroid Problems
[ ]	[ ]	Kidney Problems
[ ]	[ ]	Rheumatic Fever
[ ]	[ ]	Hepatitis or Liver Problems
[ ]	[ ]	Emotional Problems
[ ]	[ ]	Tuberculosis
[ ]	[ ]	AIDS / HIV
[ ]	[ ]	Anemia
[ ]	[ ]	Asthma
[ ]	[ ]	Epilepsy
[ ]	[ ]	Prolonged Bleeding
[ ]	[ ]	Endocrine Problems
[ ]	[ ]	Tonsils Removed
[ ]	[ ]	Adenoids Removed

Please list dates and specifics for all "Yes" answers: _____

_____

_____

_____

List any allergies:_____

_____

List medications presently being taken:_____

_____

_____

List any serious illness or operation not listed above:_____

_____

Has a physician advised the patient to take antibiotics prior to dental appointments? _____

Is the Patient currently under a physicians care?_____

Physician's Name _____

Reason _____

Dental History

Y	N	
[ ]	[ ]	Any injury to face, mouth, teeth?
[ ]	[ ]	Thumb, finger or lip sucking habit(s)?
[ ]	[ ]	Any speech problems?
[ ]	[ ]	Mouth breathing when asleep, awake?
[ ]	[ ]	Any known missing permanent teeth?
[ ]	[ ]	Any known extra permanent teeth?
[ ]	[ ]	Any teeth removed by extraction? When?_____
[ ]	[ ]	Tongue thrust?
[ ]	[ ]	Any wind instruments played?
[ ]	[ ]	Clenching or Grinding of teeth?
[ ]	[ ]	Chronically sore or bleeding gums?
[ ]	[ ]	Jaw Pain, popping, grinding, locking?
[ ]	[ ]	Difficulty chewing or swallowing food?
[ ]	[ ]	Frequent Headaches? If Yes, how frequent?_____
[ ]	[ ]	Muscle tenderness or stiffness in neck/jaw?
[ ]	[ ]	Ringing of ear, dizziness?
[ ]	[ ]	Previous treatment for TMJ or joint problems?

Please list dates and specifics for all "Yes" answers: _____

_____

_____

_____

Does patient visit his/her dentist regularly?_____

Has an Orthodontist been consulted previously? _____

Reason: _____

_____

Has patient experienced a sudden increase in height?:____

_____

Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws? Explain_____

_____

Please list any other dental information known, and not listed above: _____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes.

Signature (Guardian's signature if a minor) _____Date__/__/__

Relationship to the patient_____