FAMILY DENTISTS
KARL BREUCKMANN, DDS
www.OlatheFamilyDentists.com
913-782-6533

Patient Information

Name_____

Preferred Name _____ Date of Birth_____

Address_____City_____ST_____Zip_____

Cell Phone(_____)_____-_____ Home Phone(_____)_____-_____

S.S.N._____ Email Address_____

Employer _____ Work Phone(_____)_____-_____

Work Address_____

Referred By_____

Responsible Party (If someone other than the Patient)

Name_____Home Phone(_____)_____

Cell Phone(_____)_____-_____Email_____

Address_____City_____ST_____Zip_____

Employer _____ Work Phone(_____)_____-_____

Dental Insurance Information

Name of Insured_____Date of Birth_____

Employer_____

Insurance Company_____ Phone(_____)_____-_____

S.S.#/I.D.#_____Group #_____

Emergency Contact

Name_____ Relationship _____

Phone (_____)_____ Alt Phone (_____)_____

Authorization and Release

I certify the above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and records of any treatment rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I authorize my insurance company to pay directly to the dentist from which services were provided. I understand my dental insurance may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____Date_____

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Acknowledgement of Receipt of Notice Of Privacy Practices

I have seen and/or received a copy of this office's Notice of Privacy Practices.

_____
Please Sign Your Name

_____
Date

You May Refuse to Sign This Acknowledgement

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgment.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify)_____

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my dependents dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2 % late charge (18% APR) or a $5 late fee may be added to my account. If required, I also understand a check of my credit history may be made.
5. I understand that 48 hours' notice is required for schedule changes and that a fee/or loss of deposit may apply should notice not be received.

Patient's
Signaure _____ Date _____

Parents/Responsible Party's Signature _____

Relationship to the Patient _____ Date _____

Witness _____ Date _____

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We are happy to have you join our great family of patients. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you!

Name _____ Birthdate _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ City, State_____

How often do you have dental examinations? _____

How often do you brush your teeth? _____How often do you floss? _____

What other dental aids do you use? (waterpik, electric toothbrush, etc.) _____

Do you have any dental concerns? □ Yes □ No

If yes, please describe: _____

DO YOU HAVE CONSISTENT PROBLEMS WITH:

Sensitive teeth? □ Yes □ No
If yes, sensitivity to:
□ Hot □ Cold □ Pressure □ Sweets
Dry mouth or excessive thirst? □ Yes □ No
Difficulty chewing? □ Yes □ No
Popping/clicking in your jaw? □ Yes □ No
Jaw pain? □ Yes □ No
Headaches? □ Yes □ No
Difficulty in opening/closing the mouth? □ Yes □ No
Tired jaws, especially in the morning? □ Yes □ No
Unpleasant odor or taste in your mouth? □ Yes □ No
Swelling/lumps/sores in your mouth or jaw? □ Yes □ No
Bleeding Gums? □ Yes □ No
Food catching between teeth? □ Yes □ No
Loose teeth or change in your bite? □ Yes □ No
Discolored teeth? □ Yes □ No
Broken Teeth or Fillings? □ Yes □ No

HAVE YOU EVER HAD:

Orthodontic treatment (braces)? □ Yes □ No
Oral surgery (tooth extractions)? □ Yes □ No
Periodontal (gum) treatment? □ Yes □ No
A bite plate or mouth guard? □ Yes □ No
A serious injury to the mouth or head? □ Yes □ No
Treatment for TMJ (jaw joint) disorders? □ Yes □ No
Anorexia and/or Bulimia? □ Yes □ No
Frequent Heartburn/GERD? □ Yes □ No

DO YOU:

Clench or grind your teeth? □ Yes □ No
Bite your lips or cheeks regularly? □ Yes □ No
Bite your fingernails? □ Yes □ No
Hold foreign objects with your teeth? (pens, nails, etc.)
□ Yes □ No
Mouth breathe while awake or asleep? □ Yes □ No
Snore or have any other sleeping disorders? □ Yes □ No
Regularly chew/suck on hard candy or mints? □ Yes □ No
Drink soft drinks or energy drinks? □ Yes □ No
Smoke/chew tobacco or use other tobacco products?
□ Yes □ No
If yes, please describe the type, amount, and number of years using tobacco:
_____
_____

Are you nervous or fearful of dental treatment?
□ Yes □ No
Are you dissatisfied with the way your teeth look?
□ Yes □ No
How would you rate your smile?
Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe:
_____
_____
_____

I would like to learn more about: □ Invisalign □ Whitening □ Cosmetic Dentistry □ Implants
□ CEREC (one visit) Crowns □ Snoring/Sleep Apnea Appliance

Karl Breuckmann, DDS

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No; Please Explain:_____
Have you ever been hospitalized or had a major operation? Yes No; Please Explain:_____
_____
Have you ever had a serious head or neck injury? Yes No; Please Explain:_____
Are you taking any medications, vitamins, supplements, pills, or drugs? Yes No; Please List_____
_____
_____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you taking any "Bone Density Medication" (Bisphosphonate)? (e.g. Fosamax, Boniva, Actonel, Didronel, Reclast, etc.) Do you take this medication orally or intravenously? _____
How often do you take this medication? _____
How long have you been taking this medication? _____
Are you taking any type of blood thinner, including aspirin? Yes No
Do you take pre-medication for joint replacement or heart problems? Yes No
Are you on a special diet? Yes No; Explain: _____
Do you use tobacco? Yes No; Type: _____How Often:_____
Do you use controlled substances? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs
Other: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain,
_____
_____
_____
Comments:_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Print Patient Name_____ Date of Birth_____
Signature of Patient, Parent or Guardian:_____Date_____