SBA Dental Dr. Steven B. Brucki D.D.S.

PATIENT QUESTIONAIRE

Patient Nam	ne:	Add	dress:	
	State:			
Work Phone	e:Fax:		Alternative:	
	Social Security #:			
Marital Status: Driver License:				
	ne/Address			
	hdate: Employe			
	ompany Name:			
Patient Ema	il:	Kelefre	и ву:	
1.	Heart Problems?			(Y/N)
2.	Diabetes?			(Y/N)
3.	Rheumatic Fever?			(Y/N)
4.	Epilepsy?			(Y/N)
5.	High Blood Pressure?			(Y/N)
6.	Low Blood Pressure?			(Y/N)
7.	Respiratory Disease or Trouble Brea	thing?		(Y/N)
8.	Fainting Spells?			(Y/N)
9.	Prolonged Bleeding?			(Y/N)
10.	Healing Complications?			(Y/N)
11.	Ear Problems?			(Y/N)
12.	Nervous or Mental Problems?			(Y/N)
13.	Hepatitis (If yes, Date:)		
14.	Venereal Disease (If yes, Date:)		
15.	HIV or Aides?			(Y/N)
16.	Cancer?			(Y/N)
17.	Periodontal Disease?			(Y/N)
18.	Previous injuries to the face, mouth	, or jaw?		(Y/N)

19.	Missing teeth that have not been replaced?	(Y/N)
20.	Do you have any dental problems that require immediate care?	(Y/N)
21.	Do your gums ever bleed?	(Y/N)
22.	Do you have pain or clicking in your jaw joints?	(Y/N)
23.	Have you had an oral exam with x-rays within the last two years?	(Y/N)
24.	Do you have your teeth professionally cleaned regularly?	(Y/N)
25.	How often?	
26.	Is there anything about your smile or bite that you do not like?	(Y/N)
27.	Do you like the color of your teeth?	(Y/N)
28.	Do you smoke or use any form of tobacco?	(Y/N)
29.	Do you have a physician? (Name: Phone:)
30.	Are you pregnant?	(Y/N)
31.	Have you had any problems with anesthetic?	(Y/N)
32.	Please list any drugs you are allergic to	
33.	Any reason that you could not have normal dental treatment?	(Y/N)
34.	List Drugs you are presently taking?	
35.	Other?	(Y/N)
IN C	CASE OF EMERGENCY	
NO ⁻	TIFY: PHONE:	
PAT	TENT SIGNATURE:	

SBA Dental Dr. Steven B. Brucki D.D.S. 36100 Brookside Dr. Suite LL40

	Gurnee, IL 60031
	Patient Name
LEASE OF INFORMATION	<u>v</u>
ereby authorize Steven E	

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I h e all medical information that may be necessary for payment on my behalf for the dental health care services rendered to the above named patient. This authorization may be revoked in writing at any time except to the extent that actions have been take in reliance thereon.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any dental care provided to the above patient; I hereby assign, transfer, and get over to Steven B. Brucki & Associates of Gurnee D.D.S., LTD all of the rights, title and interest to any and all dental reimbursement under any insurance policy, subscription certificates or health benefits indemnification agreement otherwise payable to me for those services rendered at Steven B. Brucki & Associates of Gurnee D.D.S., LTD.

GUARANTEE OF PAYMENT

I understand that I will be fully responsible for payment of any and charges not covered by dental insurance at the current rates established by Steven B. Brucki & Associates of Gurnee D.D.S., LTD in collecting the amounts guaranteed hereby, including all court costs, reasonable attorney fees, and all the other collection expenses.

Names of Responsible Partio	es
Signatures of Responsible Party	Date