SBA Dental

Dr. Steven B. Brucki D.D.S.

PATIENT QUESTIONAIRE

Patient Name: _____ Address: _____

City: _____ State: _____ Zip_____ Home Phone: _____

Work Phone: _____Fax:_____Alternative:_____

Birthdate: _____ Social Security #:_____ Sex (M / F)

Marital Status: _____ Driver License: _____ Insurance (Y / N)

Insured Name/Address_____ Social Security #:_____

Insured Birthdate: _____ Employer Name: _____

Address: _____ City: _____ State: _____Zip:_____

Insurance Company Name: _____ Phone: _____

Patient Email: _____ Referred By: _____

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 Breathing? . . . . . (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 CASE OF EMERGENCY

NOTIFY: _____ PHONE: _____

PATIENT SIGNATURE: _____

SBA Dental
Dr. Steven B. Brucki D.D.S.
36100 Brookside Dr.
Suite LL40
Gurnee, IL 60031

_____

Patient Name

RELEASE OF INFORMATION

I hereby authorize Steven B. Brucki & Associates of Gurnee D.D.S., LTD to release 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 Parties

_____

Signatures of Responsible Party Date