HEALTH QUESTIONAIRE

Name (Dr.,Mr.,Mrs.,Ms.) _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Employer _____ Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Wk phone _____

Cell Phone _____ Email _____

Date Of Birth _____ Social Security No. _____

DENTAL INSURANCE

Policy Holder Name(if diff from above) _____

Employer (Name and Address) _____

Dental Carrier _____ Group No. _____

Policy No. _____ Insured S.S. No. _____

Insured Date Of Birth _____

MEDICAL HISTORY

All information on this Health Questionnaire is for our use in this office only. We will not share any of the information without your permission.

Date of Last Medical Exam _____ Dental Exam _____

Do You Have or Have You Ever Had the following:

	Yes	No		Yes	No
Anemia	_____	_____	Abnormal Heart Condition	_____	_____
Diabetes	_____	_____	Abnormal bleeding from		
Hepatitis	_____	_____	from a cut	_____	_____
Allergies	_____	_____	Rheumatic Fever	_____	_____
To Penicillin	_____	_____	Heart Murmur	_____	_____
To Local Anesthetic	_____	_____	Tuberculosis	_____	_____
Are You Taking Any Medication	_____	_____			

If so, what? _____

Other Physical Conditions _____

Do You Have Any Reason to Suspect You Might Have AIDS? ..... Yes ___ No ___

Have You Been In Contact With Anyone With AIDS? ..... Yes ___ No ___

Have You Ever Been Tested For AIDS? ..... Yes ___ No ___

Date of Test _____ Result of Test: Positive _____ Negative _____

DENTAL HISTORY

	Yes	No		Yes	No
Are Your Teeth Sensitive to:					
Heat	_____	_____	Have you ever experienced		
Cold	_____	_____	problems with Novocaine?	_____	_____
Sweets	_____	_____	Have you had a complete dental		
Biting Pressure	_____	_____	examination, including x-rays		
			within the past 3 years?	_____	_____
Do you favor one side?	_____	_____	Do you have your teeth cleaned		
Do any teeth feel loose?	_____	_____	regularly? How often?	_____	_____
Do you have any food traps?	_____	_____			
Have you noticed any gum swelling			Do you have all or most of your		
around any teeth?	_____	_____	natural teeth?	_____	_____
Do your gums bleed when brushing? ____		_____	Have any missing teeth been		
Have you had any previous injuries			replaced?	_____	_____
to the face or jaws?	_____	_____	If not replaced, are you concerned		
Have your gums ever been treated? _____		_____	about the possible outcome?	_____	_____
Do you seem to strike some teeth			Would you like to keep		
before others when closing?	_____	_____	all of your natural teeth?	_____	_____
Have you ever had your			Have you been instructed		
bite adjusted?	_____	_____	regarding proper home care?	_____	_____
			Do you use dental floss or tape? ..	_____	_____
			Do you smoke or use tobacco?	_____	_____

In case of an emergency, who should be notified? _____ Phone _____

Relationship to patient _____

Who referred you to Dr. Fleischut? _____

FINANCIAL POLICY

I, the undersigned, do understand that I am solely responsible for my account balance. I understand that Dr. Fleischut's office will do everything to assist in the processing of any and all insurance claims. I also understand that a finance charge may be applied to accounts unpaid after 60 days. Finance charge computed By a periodic rate of 1.50% per month, which is the annual rate of 18%.

Signed: _____ Date: _____

Witnessed: _____ Date: _____