NAME ______________________________ DATE ______________

DATE OF BIRTH ________________ AGE ________

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please inquire about any questions which are not understood. It will help us provide you with the best possible care.

Physician's name & address ________________________________

____

Date of last medical exam ____________________

Have you had any of the following:

1. Nitrous oxide (sweet air) in a dental office ...... YES NO
2. General anesthesia in a dental office .... YES NO
3. Sensitivity or allergy to any medicines (including "novocaine" and antibiotics .... YES NO
4. Asthma or any other allergies .... YES NO
5. High blood pressure .... YES NO
6. Low blood pressure .... YES NO
7. Heart condition (including heart murmur) .... YES NO
8. Rheumatic fever .... YES NO
9. Stomach ulcers .... YES NO
10. Diabetes .... YES NO
11. Tuberculosis .... YES NO
12. Kidney problems .... YES NO
13. Liver disorders (ex. jaundice or hepatitis) ...... YES NO
14. Are you pregnant .... YES NO
15. Thryoid condition .... YES NO
16. Please circle if you smoke:

    cigarettes pipes cigars

16. Do you smoke more than one pack a day .... YES NO
17. Are any medications currently being taken .... YES NO
18. Any disease, conditions or problems not listed above:

____

CURRENT MEDICATIONS (List)

____

Patient's signature

MICHAEL R. SCHWARZ, D.D.S., P.A., F.A.G.D.
Fellow, Academy of General Dentistry

Dentistry for the Family
923 Park Avenue
Plainfield, NJ 07060
Telephone: (908) 754-9373

NAME (circle) Dr / Mr / Mrs / Ms / Miss ____________________

ADDRESS ____________________

PHONE (home) __________ (work) __________ (cell) __________

Birth Date __________ Age ____ Social Security # __________

Driver's License # __________ E mail __________

Spouse/Partner Name __________ Birth Date __________

Spouse/Partner Social Security # __________

Emergency Contact __________ Phone __________

Medical Physician __________ Phone __________

Primary Insurance Co __________ Phone __________

Employer Name __________ Group ID# __________

Name of Primary Insured __________ Insurance ID/SS# __________

Address of Primary Insured ____________________

Name of Secondary Insured __________ Insurance ID/SS# __________

Address of Secondary Insured ____________________

Employer Name __________ Group ID# __________

Secondary Insurance Co __________ Phone __________

As a courtesy to our patients our office will bill your insurance for all services rendered. Please be advised that all deductibles and co-payments are due at the time of service. BY SIGNING MY NAME BELOW I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES AND COSTS THAT MAY BE INCURRED TO COLLECT THESE BALANCES INCLUDING ADDITIONAL ATTORNEY AND COLLECTION FEES.

____________________ __________ ____________________

Signature of Responsible Party Date Witness