DENTAL QUESTIONNAIRE FOR DR M. LEIPSIG

Please fill in full details of the person responsible for the account, i.e. Main member	
Surname:	Full Names:
Title:	I.D. No:
Residential Address:	
Postal Address:	
Employer:	Work Tel. No:
Home Tel. No:	Cell No.:
Next of kin or close friend: (Name and Tel)	
Medical Aid Name:	Membership No:
Name Of Main Member:	Date Of Birth:
Dependents: (list all)	

PATIENT DETAILS:	
Surname:	Full Names:
Title:	I.D. No:

MEDICAL HISTORY: (If YES, please specify)
Are you allergic to any medicine?
Do you have any heart problems?
Have you had a transplant (hip, kidney, etc.) or a bypass?
Have you ever had theumatic fever?
Are you a bleeder?
Do you have lung disease?
Are you diabetic?
Are you HIV positive?
Have you ever had hepatitis?
Are you pregnant?
Are you on any medication?
Are you a smoker?

DENTAL HISTORY: (If YES, please specify)
What is you main complaint or reason for visit?
Do you suffer from any of the following:
Loose teeth?
Receding gums?
Clenching/Grinding?
Bleeding gums?
Bad breath or taste?
Sensitivity?
Other?