

**Please mark with an X if you have any of the following**

- |  |   |
|--|---|
| <input type="checkbox"/> Abnormal blood pressure                               | <input type="checkbox"/> Heart Disease                  |
| <input type="checkbox"/> AIDS/HIV  | <input type="checkbox"/> Heart Murmur                   |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Hepatitis type                 |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Jaundice                       |
| <input type="checkbox"/> Asthma/hay fever                                      | <input type="checkbox"/> Kidney or liver transplant     |
| <input type="checkbox"/> Bleeding abnormally with dental extraction or surgery | <input type="checkbox"/> Mitral Valve Prolapse          |
| <input type="checkbox"/> Blood disease   | <input type="checkbox"/> Nervous disorders              |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Radiation or x-ray for disease |
| <input type="checkbox"/> Chest or heart pains                                  | <input type="checkbox"/> Rheumatic fever                |
| <input type="checkbox"/> Chronic sores or boils                                | <input type="checkbox"/> Shortness of breath            |
| <input type="checkbox"/> Congenital heart disease                              | <input type="checkbox"/> Sinus problems                 |
| <input type="checkbox"/> Diabetes Type   | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Emphysema   | <input type="checkbox"/> Swollen feet                   |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Thyroid problems               |
| <input type="checkbox"/> Fainting or dizziness                                 | <input type="checkbox"/> Tuberculosis or lung disease   |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Ulcer                          |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Venereal Disease               |

**Women only:**

- Are you pregnant?  
 Due date  
 Are you nursing?  
 Have you reached menopause?  
 Do you take birth control pill?  
 Do you take hormones?

**Dental History**

Reason for today's visit: \_\_\_\_\_

Last Dentist Visit: \_\_\_\_\_

Last xrays: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

**Do you or have you had:**

- |  |   |
|--|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Lip or cheek biting            |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Blisters, mouth or lips       | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Chew on one side of the mouth | <input type="checkbox"/> Periodontal treatment (gums)   |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Sensitivity to cold            |
| <input type="checkbox"/> Dry mouth                     | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Fingernail biting             | <input type="checkbox"/> Sensitivity to sweet           |
| <input type="checkbox"/> Grinding or clenching         | <input type="checkbox"/> Smoke. How much?               |
| <input type="checkbox"/> Jaw pain or tenderness        | <input type="checkbox"/> Swollen or tender gums         |

Are you satisfied with the appearance of your teeth? If no explain \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge. It is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I made in the completion of the form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**The Restorative Dental Group of Cambridge**  
 RESTORATIVE, IMPLANT AND COSMETIC DENTISTRY

181 Concord Avenue  
 Cambridge, MA 02138-2317  
 Phone (617) 492-6070  
 Fax: (617) 576-3848

- STEPHEN C. DULONG, D.M.D.
- ELLIOT KRONSTEIN, D.D.S.
- JOHN C. MCMANAMA, D.D.S.
- DAVID S. FISH, D.M.D.
- ARISTIDES EXARCHOS, D.M.D.
- ALAN V. SULIKOWSKI, D.M.D.
- CHRISTINE LO, D.M.D.
- BERT BRANDSE, D.M.D.
- MARIO GATTI, D.M.D.

## Privacy Notice Written Acknowledgement

Patient name: \_\_\_\_\_ Record Number: \_\_\_\_\_

I understand that The Restorative Dental Group of Cambridge may use my health information for treatment, payment and health care operations. I have been given a copy of the Restorative Dental Group of Cambridge Notice of Privacy Practices that describes how my information is used and disclosed. I understand that The Restorative Dental Group of Cambridge has the right to change this notice at any time. I may obtain a record copy of the notice by contacting the Records Administrator for the Restorative Dental Group of Cambridge (location where I receive my health care services).

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Personal Representative

\_\_\_\_\_  
Privacy Notice Effective Date

\_\_\_\_\_  
Witness

## Document of Good Faith

Notice of Privacy and Written Acknowledgement provided to patient/parent/legal guardian or other personal representative, by:

- Hand Delivered
- Sent to the patient/parent/legal guardian at the address of record, or
- Sent to the patient/parent/legal guardian at the email address of record

Patient/parent/legal guardian or other representative:

Expressly states they decline to sign Written Acknowledgement of receipt of Notice because

\_\_\_\_\_

- Has not expressed decline, but has failed to return the signed Written Acknowledgement, despite the following good faith efforts to obtain the return of the Acknowledgement:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Health Questionnaire

**Full Name:** \_\_\_\_\_

**Residence Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State/Zip:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State/Zip:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Business:** \_\_\_\_\_

**Cell:** \_\_\_\_\_

**Sex:**    M    F **DOB**    /    /    (MM/DD/YY)

**Occupation** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

**Social Security#** \_\_\_\_\_

**Physician name:** \_\_\_\_\_

**Date of last physical:** \_\_\_\_\_

**Name of Dental Insurance Company:** \_\_\_\_\_

**If one of the following please complete:**

**Delta ID #** \_\_\_\_\_

**Delta Group #** \_\_\_\_\_

**Dental BC/BS ID #** \_\_\_\_\_

**In case of emergency, contact:**  
**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone Home** \_\_\_\_\_ **Work** \_\_\_\_\_

### Medical History

Are you now or have you been in the last 5 years under the care of a physician? \_\_Y \_\_N

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Have you ever had any serious illness? \_\_Y \_\_N

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Have you ever been a patient at a hospital? \_\_Y \_\_N

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Are you taking any medications (vitamins, supplements, etc.) at this time? \_\_Y \_\_N

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Is there any medications you cannot take because you are allergic to or make you sick? \_\_Y \_\_N

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Have you ever had a local anesthetic? \_\_Y \_\_N

Any adverse reaction? \_\_\_\_\_

\_\_\_\_\_