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

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

__ Bad breath
__ Bleeding gums
__ Blisters, mouth or lips
__ Chew on one side of the mouth
__ Clicking or popping jaw
__ Dry mouth
__ Fingernail biting
__ Grinding or clenching
__ Jaw pain or tenderness
__ Lip or cheek biting
__ Loose teeth or broken fillings
__ Orthodontic treatment (braces)
__ Periodontal treatment (gums)
__ Sensitivity to cold
__ Sensitivity to heat
__ Sensitivity to sweet
__ Smoke. How much?
__ 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

Questionnaire

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.
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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? _____

_____

_____

Over .....