CUSHING & RABINOVITZ, P.C.

ZORI RABINOVITZ D.M.D., M.S. ◆ MANUEL MOLINA D.M.D., M.S. DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY

PERIODONTICS AND DENTAL IMPLANTS

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

By what name do you prefer us to call you? _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Number: _____

E-mail: _____ Date of Birth: _____ Social Security Number: _____

Male: ❑ Female: ❑ Check appropriate box: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Student

Physician: _____ City: _____

Dentist: _____ City: _____

Name of Employer: _____ Occupation: _____

Employer Address: _____ City: _____ Zip: _____

Spouses Name: _____ Occupation: _____

Name of spouses Employer: _____ Phone Number: _____

Employer address: _____ City: _____ Zip: _____

Where may we confirm your appointment? ❑ Home ❑ Office ❑ Cell ❑ E-mail

Dental Insurance Information

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Is this person currently patient in this office? ❑ Yes ❑ No

Name of Employer: _____ Insurance Company: _____

Social Security number: _____ ID Number: _____

Group ID Number: _____ Insurance Address: _____

Phone number: _____

Do you have any other dental insurance? ❑ No ❑ Yes If yes, please complete the following:

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Is this person currently patient in this office? ❑ Yes ❑ No

Name of Employer: _____ Insurance Company: _____

Social Security number: _____ ID Number: _____ Group ID Number: _____

Insurance Address: _____ Phone number: _____

In case of Emergency notify:

Name: _____ Relationship: _____

Home Number: _____ Cell Phone: _____

I hereby authorize payment of dental benefits, otherwise payable to me directly, to Cushing& Rabinovitz, P.C.

_____ _____

Signature Date

60 WORCESTER ROAD + FRAMINGHAM, MA 01702 + PHONE (508) 879-1100 + FAX (508) 879-6644

350 EAST MAIN STREET + MILFORD, MA 01757 + PHONE (508) 634-0011 + FAX (508) 634-0012

OFFICE@SELECTPERIO.COM + WWW.SELECTPERIO.COM

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I have been offered a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

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PERIODONTICS AND DENTAL IMPLANTS

Name _____ **Date** _____

Date of Birth _____ **Age** _____ **Height** _____ **Weight** _____

PHYSICIAN **Name:** _____

Address: _____

_____

HEALTH QUESTIONNAIRE

Yes ☐	No ☐	Are you in good health?
Yes ☐	No ☐	Has there been any change in your general health within the past year? My last physical examination was on _____.
Yes ☐	No ☐	Are you now under the care of a physician? If so, what is the condition being treated and by whom? _____ _____
Yes ☐	No ☐	Have you been hospitalized or had a serious illness within the past (5) years? If so, what was the problem? _____ _____
Do you have or have you had any of the following problems or diseases?		
Yes ☐	No ☐	Rheumatic fever or rheumatic heart problems.
Yes ☐	No ☐	Congenital heart lesions.
Yes ☐	No ☐	Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).
Yes ☐	No ☐	Heart murmur.
Yes ☐	No ☐	Asthma or hay fever.
Yes ☐	No ☐	Skin problems.
Yes ☐	No ☐	Fainting spells or seizures.
Yes ☐	No ☐	Diabetes.
Yes ☐	No ☐	Hepatitis, jaundice or liver disease.
Yes ☐	No ☐	HIV.

Yes ☐	No ☐	AIDS.
Yes ☐	No ☐	Hip replacement, artificial joint.
Yes ☐	No ☐	Osteopenia and/or osteoporosis.
Yes ☐	No ☐	Arthritis and/or rheumatism.
Yes ☐	No ☐	Stomach ulcers, acid reflux.
Yes ☐	No ☐	Kidney trouble.
Yes ☐	No ☐	Thyroid, adrenal disease.
Yes ☐	No ☐	Tuberculosis.
Yes ☐	No ☐	Low blood pressure.
Yes ☐	No ☐	Venereal disease.
Yes ☐	No ☐	Epilepsy.
Yes ☐	No ☐	Eating disorder, bulimia, anorexia
Yes ☐	No ☐	Do you have any blood disorder such as anemia?
Yes ☐	No ☐	Do you have a persistent cough?
Yes ☐	No ☐	Do you cough up blood?
Yes ☐	No ☐	Have you had radiation or chemotherapy??
Are you taking any of the following?		
Yes ☐	No ☐	Antibiotics or sulfa drugs.
Yes ☐	No ☐	Anticoagulants (blood thinners).
Yes ☐	No ☐	Medicine for high blood pressure.
Yes ☐	No ☐	Cortisone (steroids).
Yes ☐	No ☐	Tranquilizers.
Yes ☐	No ☐	Aspirin.
Yes ☐	No ☐	Insulin, tolbutamide (Orinase) or similar drugs.
Yes ☐	No ☐	Digitalis or drugs for heart trouble
Yes ☐	No ☐	Nitroglycerin.
Yes ☐	No ☐	Antihistamine.
Yes ☐	No ☐	Dilantin.
Yes ☐	No ☐	Other _____

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Yes ☐	No ☐	Do you have any disease, condition or other problems not listed above that you think I should know about? If so, please explain _____ _____ _____.
Yes ☐	No ☐	Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?

ALLERGIES		
Are you allergic or have you reacted adversely to:		
Yes ☐	No ☐	Local anesthetics (Novocain and xylocaine).
Yes ☐	No ☐	Penicillin or any other antibiotics.
Yes ☐	No ☐	Sulfa drugs.
Yes ☐	No ☐	Aspirin.
Yes ☐	No ☐	Codeine or other narcotics.
Yes ☐	No ☐	Other _____.

WOMEN		
Yes ☐	No ☐	Are you pregnant? If so, how many months? _____ _____.
Yes ☐	No ☐	Do you have any problems associated with your menstrual period?
Yes ☐	No ☐	Are you currently in menopause?
Yes ☐	No ☐	Are you post-menopausal?
Yes ☐	No ☐	If so, are you or have you been on a hormonal supplement?
Yes ☐	No ☐	Have you ever or are you now taking Fosamax?
Yes ☐	No ☐	Have you taken birth control pills?

For completion by the dentist:

_____
_____
_____
_____.

As a patient, it is your responsibility to inform the dentist if you are taking any prescription and/or non-prescription medication, pills, vitamins, supplements or drugs, including "street drugs". Information provided here:

_____
_____
_____.

I hereby state that I have answered all of the questions accurately to the best of my knowledge. This form will reveal my complete medical history and assist my dentist in providing the best care possible. I will inform my dentist of any change in my health and/or medication. I will not hold any dentist or dentists of this practice or any member of the staff responsible for any errors or omissions that I have made in completion of this form.

_____ _____ _____

Signature of the Patient (or guardian) **Date** **Reviewed by**