CUSHING & RABINOVITZ, P.C.

ZORI RABINOVITZ D.M.D., M.S. ◆ SIMON BERNSTEIN D.D.S., M.S. DIPLOMATES, 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

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PERIODONTICS AND DENTAL IMPLANTS

Name ______________________________ **Date** ______________

Date of Birth ________________ **Age** ________ **Height** __________ **Weight** ________

PHYSICIAN **Name:** ______________________________
Address: ______________________________
____

HEALTH QUESTIONNAIRE

Yes	No	
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	
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:

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____

____.

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**