

Are there any dental concerns you would like to discuss today? \_\_\_\_\_

Are you in discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last X-rays \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Bad breath              | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets     |
| <input type="checkbox"/> Bleeding gums           | <input type="checkbox"/> Grinding or clenching teeth   | <input type="checkbox"/> Sensitivity to cold   | <input type="checkbox"/> Sensitivity when biting   |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken filling | <input type="checkbox"/> Sensitivity to Hot    | <input type="checkbox"/> Sores or growths in mouth |

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

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Women: Are you pregnant?  Y  N Nursing  Y  N Taking birth control pills?  Y  N

Have you ever been told you needed to take antibiotics prior to any dental treatment?  Y  N

Check (✓) if you have had problems with any of the following:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive                 | <input type="checkbox"/> Cough up blood                | <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Rheumatic/ Scarlet fever       |
| <input type="checkbox"/> Anaphylaxis                       | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> High blood pressure                                | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Environmental allergies       | <input type="checkbox"/> Jaw pain   | <input type="checkbox"/> Shortness of breath            |
| <input type="checkbox"/> Arthritis, Rheumatism             | <input type="checkbox"/> Epilepsy                      | <input type="checkbox"/> Kidney disease or malfunction                      | <input type="checkbox"/> Skin rash                      |
| <input type="checkbox"/> Artificial heart valves           | <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Liver disease                                      | <input type="checkbox"/> Spina Bifida                   |
| <input type="checkbox"/> Artificial joints                 | <input type="checkbox"/> Food allergies                | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Mitral valve prolapse                              | <input type="checkbox"/> Surgical implant               |
| <input type="checkbox"/> Back problems                     | <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Nervous problems                                   | <input type="checkbox"/> Swelling of feet or ankles     |
| <input type="checkbox"/> Blood disease                     | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Pacemaker/ Heart surgery                           | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Heart problems                | <input type="checkbox"/> Psychiatric care                                   | <input type="checkbox"/> Tobacco habit                  |
| <input type="checkbox"/> Chemical dependency               | Describe _____   | <input type="checkbox"/> Rapid weight gain or loss                          | <input type="checkbox"/> Tonsillitis                    |
| <input type="checkbox"/> Chemotherapy circulatory problems | <input type="checkbox"/> Hemophilia/ Abnormal bleeding | <input type="checkbox"/> Radiation treatment                                | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Cortisone treatments              | <input type="checkbox"/> Herpes                        | <input type="checkbox"/> Respiratory disease                                | <input type="checkbox"/> Ulcer/ Colitis                 |
| <input type="checkbox"/> Cough, persistent                 |  |   | <input type="checkbox"/> Venereal disease               |

If you Check (✓) any above, please explain:

\_\_\_\_\_

List medications & dosages you are currently taking, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List drug allergies, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

**MEDICAL DOCUMENTATION:** will not be released for any other reason other than to secure the payment of benefits from the insurance company without my signed consent. I understand that I am financially responsible for all charges whether or not paid by insurance.

**APPOINTMENT:** We would appreciate at least 24 hours notice of cancellation. A charge will be made of failed or canceled appointments without prior notification of at least 24 hours. Once an appointment is made, please remember this time has been reserved for you.

**INSURANCE:** We will be more than happy to submit to your insurance company and accept assignment for benefits, however, we do ask that you pay your anticipated portion when services are rendered. We will try to give you an anticipated amount of what to expect for payments before each visit.

**CASH PAYMENTS:** We do require payment in full at each visit unless arrangements have been made in advance. We accept most charge cards, checks and cash.

Signature: \_\_\_\_\_

Date \_\_\_\_\_



Joseph A. Menna, D.M.D. and Associates

169 West Main Street, Hopkinton, MA 01748 Telephone: 508-435-9391

# Patient Information

Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

If student, name school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Email: \_\_\_\_\_

Part Time  Full Time

## Primary Dental Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## Additional Dental Insurance

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birth date \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under his plan \_\_\_\_\_

Please complete both sides