Robert L. Mandell, D.M.D., M.M.Sc.

Board Certified: practice limited to periodontics

PATIENT QUESTIONNAIRE

Home Phone #: _____

Date: _____ Cell Phone #: _____ Social Security #: _____

Last Name: _____ First Name: _____ Middle Initial: _____ I.D. No. _____

Address: _____ City: _____ Zip: _____

Spouse's Full Name: _____ Parent's Full Name: _____

Date of Birth: __ / __ / __ City of Birth: _____ Sex: M / F Marital Status: _____

Party Responsible for Payment of Account: _____

Insurance Company: _____ Insurance Number: _____

Employer: _____ Position: _____ Work Phone #: _____

Employer's Full Address: _____

Spouse's Employer: _____ Position: _____

Referred By: _____ Physician's Name: _____

Purpose of Call: _____

_____

DENTAL HISTORY

Yes	No	1. Are you now experiencing pain or discomfort in your mouth ?
Yes	No	2. Have you ever had swollen areas of the gums ?
Yes	No	3. When did you last have your teeth cleaned (Date: _____)
Yes	No	4. Have you ever had gum (periodontal) treatments ? When: _____ By Whom: _____
Yes	No	5. Do your gums bleed ?
Yes	No	6. Have you ever noticed any loose teeth ?
Yes	No	7. Have you noticed any bad mouth odors or tastes ?
Yes	No	8. Have you ever had trench mouth ?
Yes	No	9. Have you worn braces to straighten your teeth ?
Yes	No	10. Would you be disturbed if you lost your teeth and had to wear dentures ?
Yes	No	11. Are you satisfied with the appearance of your teeth ?
Yes	No	12. Are you aware of clenching, or grinding your teeth together in the daytime or at night ?
Yes	No	13. Do you have headaches regularly ? _____ Mornings _____ Evenings
Yes	No	14. Do you frequently have pain about the ears, temples or neck ?
Yes	No	15. Have you had prolonged bleeding following extractions in the past ?

RELEASE AND ASSIGNMENT

Insurance Company_____ Group Number_____ Certificate Number_____

I hereby authorize Dr. Robert L. Mandell to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care. I realize that I am responsible for payment of all non-insured charges.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Dental treatment or services, by reason of such treatment or services rendered to:

Signature:_____ Address:_____

Witness:_____ Date:_____

Robert L. Mandell, D.M.D., M.M.Sc.

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Patient Name _____ Date _____ ID No. _____

MEDICAL HISTORY

Yes	No	1. Are you having pain or discomfort at this time ?
Yes	No	2. Do you feel very nervous about having dental treatment ?
Yes	No	3. Have you ever had a bad experience in a dental office ?
Yes	No	4. Have you been hospitalized in the last two (2) years ?
Yes	No	5. Have you been under the care of a physician in the past two (2) years ?
Yes	No	6. Have you taken any medications or drugs during the past two (2) years ?
Yes	No	7. Are you allergic to or made sick by any drugs or medications ?
Yes	No	8. Have you had any excessive bleeding requiring special treatment ?

9. Circle any of the following which you presently have or have had:

Heart failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (Infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (Serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease
Heart Pacemaker	X-Ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy	Genital Herpes
Artificial Joint	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Bruise Easily	Smoker current/former	

Yes	No	10. When you walk up stairs or take a walk do you ever stop because of pain in your chest, shortness of breath, or because you are very tired ?
Yes	No	11. Do your ankles swell during the day ?
Yes	No	12. Do you use more than 2 pillows when you sleep ?
Yes	No	13. Have you lost or gained more than 10 pounds in the past year ?
Yes	No	14. Do you ever wake up from sleep short of breath ?
Yes	No	15. Are you on a special diet ?
Yes	No	16. Has your medical doctor ever said you have cancer or a tumor ?
Yes	No	17. Do you have any disease, condition, or problem not listed ?
Yes	No	18. WOMEN: Are you pregnant now ?
Yes	No	19. WOMEN: Are you practicing birth control ?
Yes	No	20. WOMEN: Do you anticipate becoming pregnant ?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Date: _____ Signature of Patient, Parent, or Guardian _____

MEDICATION SHEET

Patient Name: _____ DOB : _____

Primary Care Physician: _____

Allergies: _____

	Medication Name	Dose	Frequency	Ordering Doctor
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

_____ _____

Patient Signature Date

_____ _____

Doctor/Hygienist Signature Date

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventive Services _____

_____ Other _____ Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials ____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

_____ _____

Patient Signature Date

ROBERT L MANDELL, D.M.D., M.M.Sc.
Practice Limited to Periodontics
164 Westford Rd, Suite 8
Tyngsboro, MA 01879

[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____ (Optional)

Social Security Number: _____ (Optional)

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Form No. T303HA