Excel Dental

Let's do it together!

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PATIENT INFORMATION AND DENTAL & MEDICAL HEALTH HISTORY

PATIENT INFORMATION

Last Name: First Name: ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Mailing Address: City: State: Zip:

Email Address (will be kept confidential):

Home Phone: Cell Phone: Work Phone:

Date of Birth: / / SSN: Referred by:

If married, name of spouse: Any family members ever been treated in our office? ☐ Yes ☐ No

Employer: Address: Phone:

If full time student, name of school: In what city: Your grade:

Emergency Contact Name (outside immediate household): Relationship:
Address: Phone:

DENTAL INSURANCE

PRIMARY POLICY: Insurance Company Name: Their phone: ( )

Subscriber is: ☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other: Subscriber No: Group No:

Employer company name:

If you're not subscriber: Subscriber's full name: SSN: - -

Subscriber's date of birth: / / Work phone: ( )

SECONDARY POLICY: Insurance Company Name: Their phone: ( )

Subscriber is: ☐ Self ☐ Father ☐ Mother Subscriber No: Group No:

Employer company name:

If you're not subscriber: Subscriber's full name: SSN: - -

Subscriber's date of birth: / / Work phone: ( )

METHOD OF PAYMENT

Person responsible for account is:
☐ Self ☐ Parent ☐ Guardian ☐ Other:

Method of Payment:
☐ Insurance and any balance due is payable at time of service
☐ Payment in full at each appointment (by cash, check, or credit card)
☐ Self

Service Charge:
If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorneys' fees incurred to effect collection of this account or future outstanding balances.

AUTHORIZATION

I hereby authorize payment directly to the dental office of Excel Dental of the group insurance payments otherwise payable to me. I understand that I am respon-sible for the cost of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical records or other information about my dental treatment to third party payors and/or other health professionals.

Signed: _____

Name Printed: _____

☐ Self ☐ Parent ☐ Legal Guardian ☐ Other:

Cal. Driver's License No: _____

Date Signed: _____

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No *If yes, where?*

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth?	☐	Have you ever had problems with dental treatment in the past?	☐
Does it hurt to chew, bite or swallow?	☐	*If yes, please describe what happened:* _____	
Do your gums bleed when you brush or floss your teeth?	☐	_____	
Have you ever had periodontal (gum) treatments like scaling and root planing?	☐		
Do you have, or have you ever had, any sores or growths in your mouth?	☐	Have you ever had a reaction to, or problem with, dental anesthesia?	☐
Do you clench or grind your teeth?	☐	*If yes, please describe what happened:* _____	
Does your jaw click, pop or hurt?	☐	_____	
Do you have earaches or neck pains?	☐		
Does dental treatment make you nervous?	☐	Are you unhappy with your smile? *If yes, why? Please mark all that apply:*	☐
Have you ever experienced any of these sleep-related breathing disorders?	☐	☐ The color of your teeth ☐ The shape of your teeth	
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep		☐ The position of your teeth ☐ Other. Please describe:	
		_____	

MEDICATIONS & OTHER PRODUCTS / SUBSTANCES

Please use an "X" to mark your answers to the following questions.

	Y	N	?
Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?	☐	☐	☐
If yes, what medication are you taking? _____			
Are you taking any medication to treat **osteoporosis** or **Paget's disease**? Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®)	☐	☐	☐
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®)	☐	☐	☐
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking **hormonal replacements**?	☐	☐	☐
Do you use any form of **tobacco** or **nicotine** products (cigarettes, cigars, snuff, chew, bidis)?	☐	☐	☐
Do you use **vaping** products?	☐	☐	☐
Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons?	☐	☐	☐
If yes, what substances?_____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally			
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____			
Do you take any other **prescriptions** and/or **over-the-counter medicine**(s), **vitamins**, **herbs** and/or supplements?	☐	☐	☐
If yes, please list them here and include information about how much and how often you use each one. _____			

WOMEN ONLY: Are you:

Taking birth control pills?	☐	☐	☐
Pregnant? If yes, number of weeks: _____	☐	☐	☐
Nursing? If yes, number of weeks: _____	☐	☐	☐

ALLERGIES **Please use an "X" to mark your answers to the following questions.**

Are you allergic to or have you had an allergic reaction to:	Y	N	?
Aspirin	☐	☐	☐
Barbitruates, sedatives, or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐

	Y	N	?
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycinsulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience. _____

_____

MEDICAL & SURGERY HISTORY

Date of last physical exam: / /

Doctor's Name: Phone:

Please use an "X" to mark your answers to the following questions. Yes No ?

	Y	N	?
Are you in good physical health?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐

MEDICAL HISTORY SPECIFIC **Please use an "X" to mark your answers to the following questions.**

Do you have, or have you been diagnosed with, any of the following conditions?

	Y	N	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely), in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Astha (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus Trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Y	N	?
Cancer	☐	☐	☐
Type: _____			
Date of Diagnosis: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood Transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
High or Low Blood Pressure	☐	☐	☐
Brain (Neurological) / Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐

	Y	N	?
Digestive Health			
Gastrointestinal disease	☐	☐	☐
GE reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic Pain	☐	☐	☐
Diabetes (Type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent Infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice, or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL UPDATE AND ACCURACY

I have read my Medical History and confirm that it adequately states my past and present conditions.

Date	Exceptions	Patient's Signature	BP	Reviewed By
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect informa-tion can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

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

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____