Excel Dental

Let's do it together!

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CHILD'S INFORMATION AND DENTAL & MEDICAL HEALTH HISTORY

PATIENT INFORMATION

Last Name: First Name: Nickname: Date of Birth: / / ☐ Male ☐ Female

Parent/Guardian's Name: Relationship to Patient: ☐ Father ☐ Mother ☐ Guardian ☐ Other:_________________

Email Address (will be kept confidential):

Home Phone: Cell Phone: Work Phone:

Father's Name: Mother's Name: Guardian's Name:

I live with: ☐ Father ☐ Mother ☐ Guardian ☐ Other: __________________________

Mailing Address: City: State: Zip:

Please use an "X" to mark your answers to the following question. Have you (the adult) or the patient (the child) had?
☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active tuberculosis
Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

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:
☐ 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)

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: ____

☐ Parent ☐ Guardian ☐ Other:

Cal. Driver's License No: ______________________________________

Date Signed: ____

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? What was done at that appointment?

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

Please use an "X" to mark your answers to the following questions.	Y	N	?
Has the patient had any problem with dental treatment in the past?	☐	☐	☐
If yes, please describe what happened: ______			
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth?	☐	☐	☐
How often are the patient's teeth brushed? ______ time(s) per _______ At what time(s) of day are the teeth brushed? __________			
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth?	☐	☐	☐
If yes, please describe what happened and when it happened: ______			
Does the patient play any contact sports or participate in active recreational activities?	☐	☐	☐
If yes, please describe those activities here: ______			
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers?	☐	☐	☐
At what age did the patient stop breastfeeding? __________ At what age did the patient stop bottle feeding? __________			
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth Breathing ☐ Snoring ☐ Trouble breathing during sleep			

PATIENT'S MEDICAL HISTORY AND VACCINATION STATUS

Please list the name and phone number of the patient's physician:
Doctor's Name: ______________________Phone: ______________________
Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. ______________________

Please use an "X" to mark your answers to the following questions.	Y	N	?	
Is the patient currently being treated for any condition(s) or illness(es)?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever been hospitalized?	☐	☐	☐	When and why?
Has the patient ever been given a general anesthetic?	☐	☐	☐	
Has the patient ever had a blood transfusion?	☐	☐	☐	
Does the patient experience excessive bleeding when cut?	☐	☐	☐	
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist?	☐	☐	☐	If so, please explain why and provide the name of the doctor making that recommendation. Name: ______________ Phone: ________________
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any genetic (inherited) conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any speech difficulties?	☐	☐	☐	If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

☐ ADD/ADHD	☐ Chicken Pox	☐ Hepatitis	☐ Seizures
☐ Alcohol/Drugs	☐ Chronic sinusitis	☐ HIV/AIDS	☐ Sexually transmitted infection (STI)
☐ Anemia	☐ Diabetes	☐ Immunizations	☐ Sickle Cell Anemia
☐ Arthritis	☐ Ear aches	☐ Kidney problems	☐ Thyroid issues
☐ Asthma	☐ Epilepsy	☐ Liver problems	☐ Tobacco/Vaping
☐ Bladder problems	☐ Fainting	☐ Measles	☐ Tuberculosis
☐ Bleeding disorders	☐ Growth problems	☐ Mononucleosis	☐ Other: ______________
☐ Bone/Joint issues	☐ Hearing problems	☐ Mumps	______________
☐ Cancer	☐ Heart Issue	☐ Pregnancy (teens)	
☐ Cerebral Palsy	☐ Heart Murmur	☐ Rheumatic Fever	

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions. **Y N ?**

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications? .... ☐ ☐ ☐

If yes, please list them here: ______________________________

Is the patient allergic to any antibiotics (**penicillin**), pain medications (**acetaminophen, ibuprofen, opioids**) or any other medications? .... ☐ ☐ ☐

If yes, please list those medications and what happened when the patient took them: ______________________________

Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.? .... ☐ ☐ ☐

If yes, please describe the allergy and the reaction: ______________________________

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 Parent or Legal Guardian: ______________________________

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form. I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: ______________________________ Date: ______________

FOR COMPLETION BY DENTIST

Comments: ______________________________

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

Reviewed by: ______________________________ Date: ______________