



## PATIENT INFORMATION AND DENTAL & MEDICAL HEALTH HISTORY

PATIENT INFORMATION				
Last Name:	First Name:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Minor	<input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer:	Address:	Phone:		
If full time student, name of school:	In what city:	Your grade:		
Emergency Contact Name (outside immediate household):	Relationship:		Phone:	
Address:				

DENTAL INSURANCE		
<b>PRIMARY POLICY:</b> Insurance Company Name:	Their phone: ( )	
Subscriber is: <input type="checkbox"/> Self <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Spouse <input type="checkbox"/> 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: ( )	
<b>SECONDARY POLICY:</b> Insurance Company Name:	Their phone: ( )	
Subscriber is: <input type="checkbox"/> Self <input type="checkbox"/> Father <input type="checkbox"/> 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	AUTHORIZATION
<p><b>Person responsible for account is:</b>  <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:</p> <p><b>Method of Payment:</b>  <input type="checkbox"/> Insurance and any balance due is payable at time of service  <input type="checkbox"/> Payment in full at each appointment (by cash, check, or credit card)  <input type="checkbox"/> Self</p> <p><b>Service Charge:</b>            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.</p>	<p>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 responsible 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.</p> <p><b>Signed:</b> _____</p> <p><b>Name Printed:</b> _____</p> <p><input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other:</p> <p><b>Cal. Driver's License No:</b> _____</p> <p><b>Date Signed:</b> _____</p>

DENTAL HISTORY & SYMPTOMS																															
What is the reason for your visit today?																															
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, where?</i>																															
When was your last dental exam?     /     /	What was done at that appointment?																														
When was the last time you had dental x-rays taken?																															
<b>Please mark an "X" in the box ONLY if this applies to you.</b>																															
Is it hard to open your mouth? ..... Does it hurt to chew, bite or swallow? ..... 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? ..... Do you clench or grind your teeth? ..... Does your jaw click, pop or hurt? ..... Do you have earaches or neck pains? ..... Does dental treatment make you nervous? ..... Have you ever experienced any of these sleep-related breathing disorders? ... <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">Have you ever had problems with dental treatment in the past?</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;"><i>If yes, please describe what happened:</i> _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">_____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">Have you ever had a reaction to, or problem with, dental anesthesia?</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;"><i>If yes, please describe what happened:</i> _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">_____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">Are you unhappy with your smile? <i>If yes, why? Please mark all that apply:</i></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;"><input type="checkbox"/> The color of your teeth   <input type="checkbox"/> The shape of your teeth</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;"><input type="checkbox"/> The position of your teeth   <input type="checkbox"/> Other. Please describe:</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">_____</td> <td></td> </tr> </table>	<input type="checkbox"/>	Have you ever had problems with dental treatment in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, please describe what happened:</i> _____		<input type="checkbox"/>	_____		<input type="checkbox"/>	Have you ever had a reaction to, or problem with, dental anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, please describe what happened:</i> _____		<input type="checkbox"/>	_____		<input type="checkbox"/>	Are you unhappy with your smile? <i>If yes, why? Please mark all that apply:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth		<input type="checkbox"/>	<input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe:		<input type="checkbox"/>	_____	
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MEDICATIONS & OTHER PRODUCTS / SUBSTANCES	
<b>Please use an "X" to mark your answers to the following questions.</b>	
Are you taking any <b>blood thinners</b> (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? .....	Y   N   ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what medication are you taking? _____	
Are you taking any medication to treat <b>osteoporosis</b> or <b>Paget's disease</b> ? Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®) .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what medication are you taking? _____	
Are you taking, or scheduled to take, an <b>IV medication</b> 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 zoledronate (Zometa®) .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what medication are you taking? _____ How many years have you been taking it? _____	
Are you taking <b>hormonal replacements</b> ? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use any form of <b>tobacco</b> or <b>nicotine</b> products (cigarettes, cigars, snuff, chew, bidis)? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use <b>vaping</b> products? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use <b>controlled substances</b> (drugs), including marijuana, for either medicinal or recreational reasons?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally	
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, for what reason(s)? _____	
Do you take any other <b>prescriptions</b> and/or <b>over-the-counter medicine(s)</b> , <b>vitamins</b> , <b>herbs</b> and/or supplements? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, please list them here and include information about how much and how often you use each one. _____	
<b>WOMEN ONLY: Are you:</b>	
Taking birth control pills? .....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pregnant? If yes, number of weeks: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nursing? If yes, number of weeks: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

ALLERGIES Please use an "X" to mark your answers to the following questions.																					
<b>Are you allergic to or have you had an allergic reaction to:</b> Aspirin ..... Barbiturates, sedatives, or sleeping pills ..... Codeine or other narcotics ..... Hay fever/seasonal allergies ..... Iodine ..... Latex (rubber) ..... Local anesthetics ..... Metals ..... Penicillin or other antibiotics .....	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">N</td> <td style="width: 20px; text-align: center;">?</td> <td style="padding: 2px;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycinsulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">Other .....</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">Please describe any "Yes" answers and include information about your experience. _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 2px;">_____</td> </tr> </table>	Y	N	?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycinsulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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