Welcome

www.excellenceindentistry.com

Your dental health and happiness are the primary goals for our team. Please accurately complete this confidential form to help these goals become a reality for you!

About You

Today's Date:______________________________

Name: ______________________________
Last First Middle Initial

❑ Male ❑ Female I prefer to be called:______________

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birth Date: ____/ ____/ ____ SS #: ______________

Home Address: ______________________________

____
City State Zip

Home Telephone #: ______________________________

Work #: ______________Ext:___ Cell #: ______________

Email Address: ______________________________

Employer: ______________________________

Employer's Address:______________________________

Occupation:______________ How Long Held: ________

Best Time/Place to Reach:______________________

Previous/Present Dentist:______________________
(please circle)

Date of Last Dental Visit:______________________

Spouse Information

Name: ______________________________
Last First Middle Initial

Employer: ______________________________

Work #: ______________________ Ext.: ________

Birth Date: ____/ ____/ ____ SS #: ______________

Referral Information

Are other family members currently seen in our office?

❑ No ❑ Yes *location:* ______________________

name of account holder: ______________________

How did you hear about our office?

❑ Family/Friends/Co-Workers *name:* ______________

❑ Direct Mail Piece

❑ Newspaper Advertisement ❑ Television ❑ Magazine

❑ Insurance Plan *name:* ______________________

❑ Other *explain:* ______________________

Primary Dental Insurance

Insurance Co.:______________________________

Insurance Co. Address:______________________________

Insurance Co. Phone #:______________________________

Group # (Plan, Local or Policy #):______________________

Insured's Name:______________ Relation: ________

Insured's Birth Date: __/ __/ __ ID/SS #: ______________

Insured's Employer: ______________________________

Secondary Dental Insurance

Insurance Co.:______________________________

Insurance Co. Address:______________________________

Insurance Co. Phone #:______________________________

Group # (Plan, Local or Policy #):______________________

Insured's Name:______________ Relation: ________

Insured's Birth Date: __/ __/ __ ID/SS #: ______________

Insured's Employer: ______________________________

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records to the following persons who are involved in my care or payment for that care.

____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

____
Signature of Patient (or Guardian) Date

OVER →

Patient Name: ______________________ Date: __________

6 Medical History

Name of Personal Physician: ______________________

Address/Clinic: ______________ Phone #: ______________

Date of Last Visit to Any Physician: ______________________

Reason for That Visit: ______________________

List any prescription or over-the-counter medications you are currently taking (including herbal supplements) and dosages:

____

Are you allergic to any of the following? *Please check yes or no for each.*

YES	NO		YES	NO	
❑	❑	Aspirin	❑	❑	Dental Anesthetics
❑	❑	Codeine	❑	❑	Penicillin
❑	❑	Latex	❑	❑	Tetracycline
❑	❑	Sulfa	❑	❑	Erythromycin
			❑	❑	Food Allergies

If you are aware of any adverse reactions to other medications, list them here: ______________________

Do you take antibiotic premedication for dental appointments?______

Have you ever had any of the following diseases or medical problems? *Please check yes or no for each item.*

YES	NO		YES	NO	
❑	❑	Abnormal Bleeding	❑	❑	Herpes
❑	❑	Alcohol or Drug Abuse	❑	❑	High Blood Pressure
❑	❑	Artificial Bones	❑	❑	History of Endocarditis
❑	❑	Artificial Joints	❑	❑	HIV/AIDS
❑	❑	Asthma	❑	❑	Kidney Problems
❑	❑	Cancer	❑	❑	Liver Disease
❑	❑	Chemotherapy	❑	❑	Low Blood Pressure
❑	❑	Congenital Heart Defect	❑	❑	Mitral Valve Prolapse
❑	❑	Diabetes	❑	❑	Pacemaker
❑	❑	Difficulty Breathing	❑	❑	Psychiatric Care
❑	❑	Emphysema	❑	❑	Radiation Treatment
❑	❑	Epilepsy	❑	❑	Rheumatic Fever
❑	❑	Fainting Spells	❑	❑	Seizures
❑	❑	Frequent Headaches	❑	❑	Sexually Transmitted Disease
❑	❑	Heart Murmur			
❑	❑	Heart Surgery	❑	❑	Stroke
❑	❑	Heart Valve Replacement	❑	❑	Thyroid Problems
❑	❑	Hemophilia	❑	❑	Tuberculosis (TB)
❑	❑	Hepatitis	❑	❑	Ulcers

Other medical notes: ______________________

Do you use tobacco in any form? ❑ Yes ❑ No If so, what form?
❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chewing Tobacco

Are you taking any medications for Osteoporosis? ❑ Yes ❑ No

WOMEN

Are you taking Birth Control Pills/Patch/Injections? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No If yes, due date: __________
Are you nursing? ❑ Yes ❑ No

7 Dental History

What is the reason for today's visit? ______________________

____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had any serious/difficult problems with dental treatment? ❑ Yes ❑ No
If yes, please explain: ______________________

____

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had:

Orthodontic Treatment (Braces)	❑ Yes	❑ No
Oral Surgery (Extractions)	❑ Yes	❑ No
Periodontal Treatment (Gum Disease)	❑ Yes	❑ No
A bite splint or mouth guard	❑ Yes	❑ No
A serious injury to the mouth or head	❑ Yes	❑ No

Have you experienced:

Clicking or popping of your jaw	❑ Yes	❑ No
Headaches, neck or shoulder pain	❑ Yes	❑ No

Please rate the current health of your teeth and gums:
❑ Excellent ❑ Average ❑ Poor

How many times a week do you floss? __________

How many times a day do you brush? __________

8 Dental Future

What would you change about your smile or bite, if you could?

____

What is your biggest concern about having dental treatment?

____

Some of our services include: *Please check any you'd like to hear more about.*

❑ Cosmetic Dentistry	❑ TMJ Splints
❑ Teeth Whitening	❑ Bad Breath Solutions
❑ Implants	❑ Metal-Free Restorations
❑ Lumineers, Veneers	❑ Invisalign Orthodontics

I understand the information I have given today is correct to the best of my knowledge. I also understand and accept my responsibility to inform this office of any changes in my medical status.

____

Signature of Patient (or Guardian) Date

Medical History Update

I have read my medical history information and confirm it states past and present medical conditions:

Date: __________ ❑ No changes ❑ Changes—please explain: ______________________
______________________ Signature: __________

Date: __________ ❑ No changes ❑ Changes—please explain: ______________________
______________________ Signature: __________

Date: __________ ❑ No changes ❑ Changes—please explain: ______________________
______________________ Signature: __________