



We are pleased to welcome you to our dental practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____
Last Name First Name Initial
Address _____ City _____ State _____ Zip _____
Home Phone _____ Social Security No. _____ Date of Birth _____
Patient Employed By _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Business Phone _____ Cell Phone _____ Sex M F Driver's License No. _____
Fax No. _____ E-mail Address _____
In case of emergency, who should be notified? _____ Home Phone _____
Cell Phone _____ Preferred Appointment Times _____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name _____
Relation to Patient _____ Birthdate _____ Social Security No. _____
Address (if different from patient) _____ Phone _____
City _____ State _____ Zip _____
Occupation/Employer _____ Business Phone _____

DENTAL BENEFIT PLAN INFORMATION Is patient covered by a Dental Benefit Plan? Yes No If yes, please continue

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security No. _____
Employer _____ Insurance Company _____ Group No. _____
Address _____ City _____ State _____ Zip _____
Phone _____ Web Site _____

FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. If you have a dental benefit plan, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of your payment responsibility. Payment for services is due at the time services are rendered. We accept cash, check, and most major credit cards. Returned checks are subject to a \$30.00 returned check charge. If an account becomes delinquent and is referred to a collection agency, a 50% collection fee may be added to the account. We emphasize that as dental care providers, our relationship is with you, not with your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information, please don't hesitate to ask us. We are here to help.

Signature _____ Date _____

Patient, Parent, Guardian

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City _____ State _____

Is your primary source of water from a private well city, name _____

Would you like information for the following services?

- | | | |
|--|--|---|
| <input type="checkbox"/> Athletic Mouthguard | <input type="checkbox"/> Home water fluoride testing | <input type="checkbox"/> Restorative (root canals/crowns/bridges) |
| <input type="checkbox"/> Cosmetic Bonding, Crowns or Veneers | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Partial |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Sealants |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Periodontal Treatment (gum disease) | <input type="checkbox"/> TMJ evaluation and/or treatment |
| | | <input type="checkbox"/> Whitening or bleaching |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physicians's Name _____ Phone No. _____ Date of last visit _____

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, date _____

Please check the following:

- | Yes No | Yes No | Yes No | Yes No |
|---|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> AIDS | <input type="checkbox"/> <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> <input type="checkbox"/> Hemophilia, clotting | <input type="checkbox"/> <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol dependency | <input type="checkbox"/> <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> <input type="checkbox"/> Angina, chest pains | <input type="checkbox"/> <input type="checkbox"/> Cough up blood | <input type="checkbox"/> <input type="checkbox"/> HIV positive | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Jaw pain | <input type="checkbox"/> <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Kidney disease | <input type="checkbox"/> <input type="checkbox"/> tobacco habit |
| <input type="checkbox"/> <input type="checkbox"/> Artificial joints | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Nervous problems | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Back problems | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> <input type="checkbox"/> Blood disease | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart murmur | <input type="checkbox"/> <input type="checkbox"/> Recreational drug use | |
| <input type="checkbox"/> <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> <input type="checkbox"/> Heart problems | <input type="checkbox"/> <input type="checkbox"/> Respiratory problems | |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | |

WOMEN ONLY: Are you pregnant or think you might be pregnant? Yes No

Nursing Yes No

Taking Birth Control Pills/Hormones Yes No

MEDICATIONS

List any medication you are currently taking (including non-prescription drugs)

Tylenol Advil Ibuprofen Aspirin

1. _____

2. _____

Pharmacy of choice _____

Phone _____ Fax _____

ALLERGIES

Are you allergic to, or have you had any reactions to the following?

- | Yes No | Yes No | Yes No |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> <input type="checkbox"/> Sedatives | <input type="checkbox"/> <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> <input type="checkbox"/> Latex | <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Advil, ibuprofen |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Codeine | <input type="checkbox"/> <input type="checkbox"/> Other, list _____ |
| <input type="checkbox"/> <input type="checkbox"/> Other antibiotics | | |

AUTHORIZATIONS

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that providing incorrect information can be dangerous to my health. I authorize the dental staff to perform any necessary dental services with my consent that I may need during diagnosis and treatment. To the extent permitted under applicable law, I authorize release of my information relating to any dental benefit plan claim. I authorize payment of the dental benefits otherwise payable to me directly to Excellent Dental, P.C.

Signature _____ Date _____

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDC and the ADA.

To better serve our patients, we require a 24-hour notice of an appointment change.

Missed appointments may be assessed a cancellation fee.