EXCEL GENERAL & COSMETIC DENTISTRY
DENTAL PATIENT RECORD

PATIENT No. _____ ACCOUNT No. _____ TYPE _____

GET ACQUAINTED QUESTIONNAIRE

Welcome to our office. We know you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information, of course, will be held in strict confidence. Thank you for joining our family of patients.

PATIENT HISTORY INFORMATION

PLEASE PRINT

PATIENTS NAME _____ HOME PHONE _____ CELL PHONE _____

SOC. SEC. NO. _____ BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____

STUDENT: FULL TIME PART TIME SCHOOL _____ CITY _____

WOMEN: ARE YOU PREGNANT YES NO HOW MANY MONTHS _____

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT ☐ YES ☐ NO WHEN? _____

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

SOC. SEC. No. _____ DRIVER'S LICENSE No. _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ☐ YES ☐ NO

NAME _____ WHEN? _____

DENTAL INSURANCE ☐ YES ☐ NO

INSURED'S NAME _____

SS# _____ BIRTHDAY _____

EMPLOYER _____

INS. CO. Or PLAN _____

UNION/GRP. NAME _____

GRP. Or POLICY # _____ LOCAL # _____

DATE EMPLOYED _____

SECONDARY INSURANCE ☐ YES ☐ NO

INSURED'S NAME _____

SS# _____ BIRTHDAY _____

EMPLOYER _____

INS. CO. Or PLAN _____

UNION/GRP. NAME _____

GRP. Or POLICY # _____ LOCAL # _____

DATE EMPLOYED _____

HOW DID YOU HEAR ABOUT THIS OFFICE? FORMER PATIENT (WHO? _____)

☐ UNION ☐ TELEPHONE BOOK ☐ SAW BLDG/SIGN ☐ EMPLOYER

☐ ADVERTISEMENT (WHICH? _____)

☐ OTHER _____

WHY ARE YOU HERE TODAY? _____
CHECK-UP, TOOTHACHE, CONSULTATION, ETC.

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me.

_____ PATIENT

_____ DATE

Patient's Name	MEDICAL HISTORY
Patient' Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two year?_____ Yes No
   If yes, for what? _____
   Physician's Name _____ Phone_____
   Address _____ City_____ State _____ Zip_____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Have you ever taken diet drugs such as Phen-Fen? ..... Yes No
   If yes, please list name and dosage_____
4. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage_____
5. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No
   If yes, please list_____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Osteoporosis	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Side Sickle Cell Disease	Yes	No
Rheumatic fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Transplants	Yes	No
Eating Disorder	Yes	No	Alergies or hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizur	Yes	No
Diet(Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you have a history of having osteoporosis? if yes, what medication are you taking? ..... Yes No
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease, condition or problem not listed? ..... Yes No
    If yes, please list:_____
11. Women, Are you: Pregnant? Yes,___ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ **Date** _____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST