WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete this form (use ink). If you have any questions or need assistance, please ask us we will be happy to help.

EXCELLENCE IN DENTISTRY
MAKING A DIFFERENCE, ONE SMILE AT A TIME

Patient Information (Confidential)

Today's Date_____/_____/_____

Name_____ Birthday____/_____/_____ SSN_____-_____-_____
Address _____ City_____ State _____ Zip_____
Email _____ Home Phone ( ) _____ Cell Phone ( ) _____
Circle: MALE or FEMALE Check Status: ____Minor ____Single ____Married ____Divorced ____Widowed ____Separated
If Student, Name of School/College _____ City _____ State_____
Patient or Parent/Guardian's Employer_____ Work Phone ( ) _____
Business Address _____ City_____ State_____ Zip _____
Spouse/Parent/Guardian's Name_____ Employer_____ Work Phone ( ) _____
Whom may we thank for referring you? Where have you heard about us? Please check ALL that apply:
Friend/Family_____ TV/Radio _____ Website _____ Facebook/Twitter _____ Newspaper _____
(name)
Person to contact in case of emergency: _____ Phone ( ) _____ Relationship: _____
Have you been told by a physician that you need an antibiotic PREMED before receiving any dental treatments? _____ YES _____ NO
If yes, what medication is recommended by your doctor? _____
For what medical conditions? _____
Have you ever had Botox or dermal fillers? _____ YES _____ NO

Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____
Address_____ Home Phone ( ) _____
Email _____ Cell Phone ( ) _____
Driver's License# _____ Birthday _____/_____/_____ SSN _____-_____-_____
Employer_____ Work Phone ( ) _____
Is this person a patient in our office: _____ YES _____ NO

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthday _____/_____/_____ SSN _____-_____-_____ Date Employed _____/_____/_____
Name of Employer _____ Work Phone ( ) _____
Address of Employer _____ City _____ State ____ Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Ins. Co. Address _____ City _____ State ____ Zip _____
Ins. Phone Number _____

Office Policy

Cancellations and Missed Appointments
Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, we request at least 48 hours advanced notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in fees or dismissal as a patient.

Confirming Your Appointment
Your time is valuable and ours is too. To that end, we ask that you confirm your appointment. You will receive a text or email message asking you to reply with a "C" to confirm. If you respond to that first message, you will not get another reminder until the day of your appointment. If you do not respond by 12:00pm the day before, you will lose that appointment.

Payment and Insurance Authorization
Payment in full of your treatment is due no later than when services are rendered. Acceptable forms of payment include cash, Visa, Master Card, American Express, Discover, Care, Credit, and assigned insurance benefits. Patients are responsible for any balance left on the account dur to an insurance shortage or underpayment. If a balance is outstanding for more than 60 days, a $25.00 rebilling fee will be assessed for each month the balance is not paid. Payments returned dur to non-sufficient funds will be subject to a NSF fee of $25.00

I authorize the office of Excellence in Dentistry to release any information relating to my insurance claim and I authorize payment from my insurance company to be made directly to Excellence in Dentistry. I authorize Excellence in Dentistry or their agents to obtain and verify a credit report. I also understand that all fees not paid by insurance are my responsibility.

X Patient's Signature _____ Date _____

If you are completing this form for another person, please sign below and indicate your relationship to the patient.

Signature _____ Relationship _____ Date _____

Please complete reverse side

Revised 03/28/23

Today's Date_____/_____/_____

MEDICAL HISTORY

EXCELLENCE IN DENTISTRY
MAKING A DIFFERENCE, ONE SMILE AT A TIME

Patient Name_____Nickname_____Age_____

Name of Physician/and their specialty _____

Most recent physical examination_____ Purpose _____

What is your estimate of your general health? _____ EXCELLENT _____ GOOD _____ FAIR _____ POOR

1. Hospitalization for illness or injury.....	**Y N**
2. An allergic reaction to:	
Aspirin, ibuprofen, acetaminophen, codeine	**Y N**
Penicillin.....	**Y N**
Erythromycin	**Y N**
Tetracycline	**Y N**
Sulpha.....	**Y N**
Local anesthetic.....	**Y N**
Fluoride.....	**Y N**
Metals (nickel, gold, silver, _____)	**Y N**
Latex.....	**Y N**
Other _____	**Y N**
3. Heart conditions present from birth (please list) ……	**Y N**
_____	
4. Artificial heart valve.....	**Y N**
5. History of infective Endocarditis.....	**Y N**
6. Pacemaker or implantable defibrillator.....	**Y N**
7 Artificial joints (please list) _____	**Y N**
_____	
8. Rheumatic or Scarlet Fever _____	**Y N**
9. Blood pressure:	
High _____	
Low _____	
10. A stroke (taking blood thinners)	**Y N**
11. Anemia or other blood disorders	**Y N**
12. Prolonged bleeding due to a slight cut (INR>3.5)…...	**Y N**
13. Emphysema, Sarcoidosis.....	**Y N**
14. Tuberculosis.....	**Y N**
15. Asthma.....	**Y N**
16. Breathing or sleep problems (i.e., snoring, sinus) ……	**Y N**
17. Kidney disease.....	**Y N**
18. Liver disease.....	**Y N**
19. Jaundice.....	**Y N**
20. Thyroid, parathyroid disease/calcium deficiency.....	**Y N**
21. Hormone deficiency.....	**Y N**
22. High cholesterol or taking Statin drugs.....	**Y N**
23. Diabetes (HbA1c _____)	**Y N Y N**

Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N**
Y	**N** **Y** **N**
Y	**N**
Y	**N**
Y	**N**
Y	**N** **Y** **N**
Y	**N**
Y	**N**
Y	**N**
Y	**N** **Y** **N**
Y	**N**
Y	**N**

DO YOU HAVE OR HAVE YOU EVER HAD: *Please circle if applies*

24. Stomach or duodenal ulcer.....
25. Digestive disorders (i.e., gastric reflux) .....
26. Osteoporosis/Osteopenia (ie., taking bisphosphonates)
27. Arthritis .....
28. Glaucoma .....
29. Contact lenses .....
30. Head or neck injuries _____
31. Epilepsy, convulsions (seizures) _____
32. Neurologic Problems (attention deficit disorders) …….
33. Viral infections and cold sores .....
34. Any lumps or swelling in the mouth .....
35. Hives, skin rash, hay fever .....
36. Venereal disease .....
37. Hepatitis (type _____) .....
38. HIV / AIDS .....
39. Tumor, abnormal growth .....
40. Radiation therapy .....
41. Chemotherapy .....
42. Emotional problems .....
43. Psychiatric treatment .....
44. Antidepressant medication .....
45. Alcohol / drug dependency .....
46. Cancer .....

ARE YOU

47. Presently being treated for any other illness? .....

If YES, explain _____

48. Aware of a change in your general health?.....
49. Taking medication for weight management (i.e. fen-phen)
50. Taking dietary supplements .....
51. Often exhausted or fatigued .....
52. Subject to frequent headaches .....
53. Smoker or smoked previously (date you quit _____)
54. Considered a touchy person .....
55. Often unhappy or depressed .....
56. FEMALE - taking birth control pills .....
57. FEMALE - pregnant .....
58. MALE - prostate disorders .....

Y	N						
Y	N						
Y	N						
Y	N						
Y	N						
Y	N						
Y	N	Y	N				
Y	N						
Y	N						
Y	N						
Y	N						
Y	N						
Y	N						
Y	N						
Y	N	Y	N				
Y	N						
Y	N						
Y	N						
Y	N						
Y	N						

Y	N		
Y	N		
Y	N		
Y	N		
Y	N		
Y	N		
Y	N	Y	N
Y	N		
Y	N		
Y	N		

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

List all medications, supplements, and/or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ DATE_____/_____/_____

Doctor's Signature _____ DATE_____/_____/_____

Please complete reverse side

Revised 03/22/23