



Excel Dental Care
family, cosmetic & implant dentistry

3851 S. Stonebridge Drive, #100

McKinney, TX 75070

214-504-9400

www.MyExcelDental.com

PATIENT REGISTRATION & HISTORY

1. PATIENT INFORMATION

Date _____

Patient Name _____
(Last)

(First) (Middle Initial)

Soc. Sec. # _____

Address _____

City _____

State _____ **Zip** _____

E-mail _____

c Male c Female Birthdate _____

c Married c Single Age _____

c Divorced c Widowed c Separated c Minor

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone () _____

Spouse's Name _____

Birthdate _____

Soc. Sec. # _____

Spouse's Employer _____

3. PHONE NUMBERS

Home () _____

Work () _____ Ext. _____

Cell Phone () _____

Spouse's Work () _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone () _____

Work Phone () _____

2. FINANCIAL/DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Soc. Sec. # _____ **Birthdate** _____

Insurance Co. _____

Group # _____

Subscriber's Employer and Address _____

Is patient covered by additional insurance? c Yes c No

If yes, please complete:

Subscriber's Name _____

Soc. Sec. # _____ **Birthdate** _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Subscriber's Employer and Address _____

4. ACKNOWLEDGEMENTS & SIGNATURES

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Mughal's office may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient/Parent/ Guardian/Personal Representative

Date

Relationship to Patient

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature of Patient/Parent/ Guardian/Personal Representative

Date

Relationship to Patient

Doctor's Signature

Date

5. DENTAL HISTORY Reason for today's visit _____ _____ Are you in pain? _____ Former Dentist _____ City/State _____ Date of last dental visit _____ Date of last dental X-rays _____ Check the line to indicate if you have had any of the following:	Bad breath _____ Bleeding gums _____ Blisters on lips or mouth _____ Burning sensation on tongue _____ Chew on one side of mouth _____ Cigarette/pipe/cigar smoking _____ Clicking or popping jaw _____ Dry mouth _____ Fingernail biting _____ Food collection b/t teeth _____ Grinding teeth _____ Gums swollen or tender _____ Jaw pain or tiredness _____ Lip or cheek biting _____ Loose teeth or broken fillings _____	Mouth breathing _____ Mouth pain, brushing _____ Orthodontic treatment _____ Pain around ear _____ Periodontal (gum) treatment _____ Sensitivity to cold _____ Sensitivity to heat _____ Sensitivity to sweets _____ Sensitivity when biting _____ Sores/growths in your mouth _____ How often do you floss? _____ How often do you brush? _____								
	Do you have or have you had any of the following? Periodontal (Gum) Treatment _____ Braces _____ Partial Dentures _____ Dentures _____	If I could change my smile, I would: <table> <tr> <td>Make them whiter _____</td> <td>Repair chipped teeth _____</td> </tr> <tr> <td>Make them straighter _____</td> <td>Replace missing teeth _____</td> </tr> <tr> <td>Close Spaces _____</td> <td>Have a smile makeover _____</td> </tr> <tr> <td>Replace black metal fillings with tooth colored restorations _____</td> <td>Replace old crowns that don't match _____</td> </tr> </table>		Make them whiter _____	Repair chipped teeth _____	Make them straighter _____	Replace missing teeth _____	Close Spaces _____	Have a smile makeover _____	Replace black metal fillings with tooth colored restorations _____
Make them whiter _____	Repair chipped teeth _____									
Make them straighter _____	Replace missing teeth _____									
Close Spaces _____	Have a smile makeover _____									
Replace black metal fillings with tooth colored restorations _____	Replace old crowns that don't match _____									

6. HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Has your physician recommended that you take an antibiotic before dental treatment? Yes? _____ No? _____

If yes, list medication _____ Reason _____

Check the line to indicate if you have had any of the following:

AIDS/HIV _____	Epilepsy _____	Respiratory Disease _____	Children: Unhappy dental experiences _____ Injuries to mouth, teeth, head _____ Mouth habits: thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ Any speech problems _____ Orthodontic appliances worn now or ever been _____ Does your child brush teeth daily _____ Do you assist child with tooth brushing _____ Is fluoride taken in any form _____
Anemia _____	Fainting/dizziness _____	Rheumatic Fever _____	
Arthritis, Rheumatism _____	Glaucoma _____	Scarlet Fever _____	
Artificial Heart Valve _____	Headaches _____	Shortness of Breath _____	
Artificial Joints _____	Heart Murmur _____	Sinus Trouble _____	
Asthma _____	Heart Problems _____	Skin Rash _____	
Back Problems _____	Hepatitis Type _____	Special Diet _____	
Bleeding abnormally, w/extractions or surgery _____	Herpes _____	Stroke _____	
Blood Disease _____	High Blood Pressure _____	Swollen Feet or Ankles _____	
Cancer _____	Jaundice _____	Swollen Neck Glands _____	
Chemical Dependency _____	Jaw Pain _____	Thyroid Problems _____	
Chemotherapy _____	Kidney Disease _____	Tonsillitis _____	
Circulatory Problems _____	Liver Disease _____	Tuberculosis _____	
Congenital Heart Lesions _____	Low Blood Pressure _____	Tumor/growth on head/neck _____	
Cortisone Treatments _____	Mitral Valve Prolapse _____	Ulcer _____	
Cough (persistent or bloody) _____	Nervous Problems _____	Venereal Disease _____	
Diabetes _____	Pacemaker _____	Weight Loss, unexplained _____	
Emphysema _____	Psychiatric Care _____	Accident involving head or neck injury _____	
	Radiation Treatment _____		

Do you have or are you being treated for high blood pressure? cYes c No

Women: Are you pregnant? Yes No Taking birth control pills? Yes No Are you nursing? Yes No

Due Date _____

7. MEDICATIONS

The medications that I am taking are: (Please include all prescription, non-prescription, supplements and vitamins.)

Pharmacy Name _____ Tel Phone #: _____

8. ALLERGIES

Circle any and all of the following to which you are allergic:

Aspirin ♦ Sleeping Pills ♦ Codeine ♦ Dental Anesthetics ♦
 Erythromycin ♦ Ibuprofen ♦ Latex ♦ Percocet ♦ Penicillin ♦
 Tetracycline ♦ Vicodin

Other: _____
