EXCEL
DENTAL CARE
FAMILY | COSMETIC | IMPLANTS

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:

Make them whiter ___
Make them straighter ___
Close Spaces ___
Replace black metal fillings with tooth colored restorations ___

Repair chipped teeth ___
Replace missing teeth ___
Have a smile makeover ___
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 ___
Anemia ___
Arthritis, Rheumatism ___
Artificial Heart Valve ___
Artificial Joints ___
Asthma ___
Back Problems ___
Bleeding abnormally, w/extractions or surgery ___
Blood Disease ___
Cancer ___
Chemical Dependency ___
Chemotherapy ___
Circulatory Problems ___
Congenital Heart Lesions ___
Cortisone Treatments ___
Cough (persistent or bloody) ___
Diabetes ___
Emphysema ___

Epilepsy ___
Fainting/dizziness ___
Glaucoma ___
Headaches ___
Heart Murmur ___
Heart Problems ___
Hepatitis Type_____ ___
Herpes ___
High Blood Pressure ___
Jaundice ___
Jaw Pain ___
Kidney Disease ___
Liver Disease ___
Low Blood Pressure ___
Mitral Valve Prolapse ___
Nervous Problems ___
Pacemaker ___
Psychiatric Care ___
Radiation Treatment ___

Respiratory Disease ___
Rheumatic Fever ___
Scarlet Fever ___
Shortness of Breath ___
Sinus Trouble ___
Skin Rash ___
Special Diet ___
Stroke ___
Swollen Feet or Ankles ___
Swollen Neck Glands ___
Thyroid Problems ___
Tonsillitis ___
Tuberculosis ___
Tumor/growth on head/neck ___
Ulcer ___
Venereal Disease ___
Weight Loss, unexplained ___
Accident involving head or neck injury ___ ___________________________

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_____

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 ♦ Erythroymycin ♦ Ibuprofen ♦ Latex ♦ Percocet ♦ Penicillin ♦ Tetracycline ♦ Vicodin

Other:____

____