EXCEL DENTAL CARE
FAMILY | COSMETIC | IMPLANTS

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Frisco, TX 75035
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

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 _____

_____

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 ( ) _____

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	___	Mouth breathing	___
Bleeding gums	___	Mouth pain, brushing	___
Blisters on lips or mouth	___	Orthodontic treatment	___
Burning sensation on tongue	___	Pain around ear	___
Chew on one side of mouth	___	Periodontal (gum) treatment	___
Cigarette/pipe/cigar smoking	___	Sensitivity to cold	___
Clicking or popping jaw	___	Sensitivity to heat	___
Dry mouth	___	Sensitivity to sweets	___
Fingernail biting	___	Sensitivity when biting	___
Food collection b/t teeth	___	Sores/growths in your mouth	___
Grinding teeth	___		
Gums swollen or tender	___	How often do you floss? _____	
Jaw pain or tiredness	___		
Lip or cheek biting	___	How often do you brush? _____	
Loose teeth or broken fillings	___		

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

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:_____

_____