EXCEL DENTISTRY

951 W. Main St, #A Lewisville TX 75067

PATIENT INFORMATION

DATE _____
Name _____
Address _____

_____
City State Zip
Birthday _____ SEX: M ____, F ____
Status: Minor _____; Single _____; Married _____
Patient SS # _____
Occupation _____
Employer / School_____
Spouse's Name_____
Spouse's Birthday _____
Spouse's SS # _____
Spouse's Employer _____
Whom may we thank for referring you? _____

PHONE NUMBERS

Home_____
Work or Cell _____
Spouse's Phone _____

IN CASE OF EMERGENCY

Name_____
Relationship to patient _____
Home Phone _____
Work or Cell _____

DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____
Date of last dental visit_____
Date of last dental X-Rays_____

Toothache / Mouth Pain	YES	NO
Jaw pain / Pain around Ears	YES	NO
Clicking / Popping Jaw	YES	NO
Gum Bleeding or Swelling	YES	NO
Cigarette / Pipe Smoking	YES	NO
Sensitivity to HEAT / COLD / SWEET / when BITING	YES	NO
Loose / Broken Teeth or Broken Fillings	YES	NO
Food collection between the teeth	YES	NO

How often do you brush? _____; floss?_____

MEDICATIONS

List all current Medications: _____
_____
_____

TAKING ANY BLOOD THINNERS? _____
(Coumadin / Wafarin, Heparin, Plavix, Aspirin >> 500mg, ….)
PHARMACY: _____ PHONE:_____

DENTAL INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?
_____
RELATIONSHIP TO PATIENT_____
BIRTHDATE: _____ SS # _____
PHONE: _____
INSURANCE CO. _____
GROUP # _____
INSURANCE CO. PHONE _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____, and assign directly to Dr. Kathleen H. Pham, D.M.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE _____DATE _____.
RELATIONHIP TO PATIENT _____.

HEALTH HISTORY

AIDS / HIV positive	YES	NO
Anemia	YES	NO
Arthritis	YES	NO
Artificial Joints / Prostheses (Pacemaker,…)	YES	NO
Asthma / Pulmonary Emphysema	YES	NO
Bleeding Abnormally	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Epilepsy / Syncope	YES	NO
Heart Problem(s) / Heart Murmur	YES	NO
HEPATITIS: Type A__, B__, C__	YES	NO
High Blood Pressure	YES	NO
Low Blood Pressure	YES	NO
Psychiatric Care / Anxiety	YES	NO
Sinusitis	YES	NO
Stroke	YES	NO
Tuberculosis	YES	NO
WOMEN: * PREGNANT?	YES	NO
* NURSING?	YES	NO
* ON BIRTH CONTROL PILLS?	YES	NO

PHYSICIAN: _____ PHONE: _____

ALLERGIES

☐ **PENICILLIN** ☐ **LOCAL ANESTHETIC**
☐ **ASPIRIN** ☐ **LATEX**
☐ **CODEINE** ☐ **SULFA**
OTHERS _____