Excel Family Dental PC
1261 Furnace Brook Parkway, Suite 24
Quincy, MA, 02169

DENTAL REGISTRATION AND HISTORY

Patient's Name_______________________ Prefers to be called __________
First Middle Last
Sex ☐ Male ☐ Female Birthday________ Age___ S.S # _________ E-mail ______________
Address ______________________________
Home phone ________________ Mobile ____________ Work ________________
Employer____________________________ Occupation ____________
Employer address ______________________________
Spouse's/partner's name ____________________ Prefers to be called __________
Sex ☐ Male ☐ Female Birthday__________ Age___ S.S # _________ E-mail ______________
Address ☐ same______________________________
Home phone ☐ same____________ Mobile ____________ Work ________________

IN CASE OF EMERGENCY, CONTACT (SPECIFY SOMEONE NOT IN YOUR HOUSEHOLD)

Name________________________________ Relationship _________
Home phone ________________ Mobile ____________ Work ________________

DENTAL INSURANCE

PRIMARY INSURANCE

Subscriber's name ____________________
Group/policy number ____________________
Employer ____________________
Insurance company ____________________
How long have you had this coverage? __________
Relationship to the patient ________________

SECONDARY INSURANCE

Subscriber's name ____________________
Group/policy number ____________________
Employer ____________________
Insurance company ____________________
How long have you had this coverage? __________
Relationship to the patient ________________

ASSIGNMENT AND RELEASE

I certify that I , and/or my dependent, have insurance coverage with ______________________
______________________________(name(s) of the insurance company(ies))
and assign directly to ***Excel Family Dental, PC.*** 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 authorize the use of my signature on all insurance submissions.

Excel Family Dental, PC. 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. The consent will end when my current treatment plan is completed or one year from the date sign below.

Signature of patient, parent, guardian or personal representative______________________
Print of patient, parent, guardian or personal representative______________________
Date ____________________ Relationship ______________________

DENTAL HISTORY

Reason for today's visit______________________________
Former dentist ________________ Address ______________________
Phone ______________ Date of last dental visit __________ Date of last dental X-rays _________
How often do you floss? __________ brush? __________ fluoride rinse/gel? ______________

Y	N		Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Fingernail biting	☐	☐	Mouth breathing
☐	☐	Bleeding gums	☐	☐	Food collection between the teeth	☐	☐	Mouth pain, bruishing
☐	☐	Blisters on lips or mouth	☐	☐	Foreign objects	☐	☐	Orthodontic treatment
☐	☐	Burning sensation on tongue	☐	☐	Grinding teeth	☐	☐	Pain around ear
☐	☐	Chewing on one side of mouth	☐	☐	Gums swollen or tender	☐	☐	Periodontal treatment
☐	☐	Cigarette, pipe or cigar smoking	☐	☐	Jaw pain or tiredness	☐	☐	Sensitive to cold/sweets
☐	☐	Clicking or poping jaw	☐	☐	Lip or cheek biting	☐	☐	Sensitive to hot
☐	☐	Dry mouth	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitive when biting
						☐	☐	Sores or growths in your mouth