PATIENT INFORMATION AND HEALTH FORM

Last Name: ______________________ First Name: ______________________ M.I.: ________

Preferred Name: ______________________ Marital Status: ______________________

Address: ______________________ City: ______________________ Zip: ________

Home Phone: (   ) ________ - ________ Work Phone: (   ) ________ - ________

Cell Phone: (   ) ________ - ________ Spouse or alternative cell: (   ) ________ - ________

Date of Birth: _____ / _____ / _______ ☐ Female ☐ Male Soc. Sec. No: ______ - _____ - _______

Referred by: ______________________ In emergency call: ______________________

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: ______________________

Birth Date: ____________ SS#: ______________ Date Employed: ______________

Name of employer: ______________________ Work Phone Number: ______________

Address of employer: ____

Insurance Company: ______________ Group #: ______________ ID #: ______________

Insurance Address: ____

Insurance Company Phone #: ______________________

I hereby authorize payment directly to McNeeley & Shuba, DDS, Inc. of the Dental Benefits otherwise payable to me.

Signature ______________________________ Date ______________

By signing this form, you will give Sean McNeeley DDS & Mary Kay Shuba DDS, Inc. consent to use and disclose your protected health information to carry out treatment, payment, and healthcare activities. With your consent, we will email intraoral photos and x-rays to specialists like Oral Surgeons, Orthodontists, or any other dentists you choose for further treatment. This courtesy is provided to save you from redundant tests and repetitive fees

Signature ______________________________ Date ______________

DENTAL HEALTH

When was your last dental visit? ____

Have you ever had any serious problems associated with previous dental treatment?

If yes, explain: ____

Do you experience dry mouth? Yes ______ No _____

Does your jaw joint (TMJ) ever hurt? Yes ______ No _____

Do you gag easily? Yes ______ No _____

Health History

Are you presently under the care of a physician? .... Yes _____ No _____

Have you recently traveled outside of the U.S.A.? .... Yes _____ No _____

Are you taking any medications or over the counter drugs? .... Yes _____ No _____

If yes, please list them ____

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Are you allergic to any Drugs, Medications, or Latex Gloves? **Yes**_____ **No**_____

List Allergies:____

Have you ever been hospitalized? If yes, give reason and dates: ____________________

____

Do you take blood thinners? **Yes** _____ **No** ____

Do you smoke? Yes _____ No_____

Do you use smokeless tobacco? Yes _____ No_____

Women: Are you pregnant? Yes _____ No_____

Do you take birth control pills? Yes _____ No_____

Do you have or have you had in the past any of the following:

PLEASE CIRCLE ALL THOSE THAT APPLY:

Heart Valve Replacement **Congenital Heart Defects**

Any Artificial Joints: Hip, Shoulder, Knee, etc.

Heart Disease	Pacemaker
High Blood Pressure	Stroke
Bleeding; Clotting Problems	TB / Asthma / Lung Problems
Sleep Apnea	Drug / Alcohol Abuse / Rehab
Thyroid Problems	Diabetes: Type 1 Type 2
Cancer or Leukemia	Sinus Trouble
AIDS/HIV Positive	Arthritis
Intellectual/Developmental Disability	Auto-Immune Disease
Hepatitis A / B / C	Prolonged Sore Throat or Mouth Sores
Epilepsy/Seizures	Osteopenia / Osteoporosis

Staff Updates

Other Conditions Not Listed: ____

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CONSENT: The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, models, photographs, medications, and the use of local anesthetic agents.

____ Date ____________________

Patient Signature (Parent or Guardian if Child)