McNEELY FAMILY DENTISTRY

Patient Registration

Today's Date_____

Last Name _____ First Name _____ MI __ Date of Birth _____ Age _____

Sex M or F Soc. Sec. _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State ____ Zip Code _____

Email _____ Home Phone (____)_____ Cell Phone (____)_____

Driver's License # _____ Employer _____

Work Phone (____)_____ Occupation _____

Emergency Contact _____ Relationship _____ Phone (___)_____

If patient is a minor:

Name of Parent _____ Date of Birth _____Parent Soc. Sec. _____

Parent Employer _____ Parent Phone (___)_____

Person Responsible for Account _____ Relationship _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name_____ Relationship _____

Reason for today's visit?

_____

How did you hear about us? Mailer Social Media Insurance Practice Website Internet Family/Friend/ Coworker

Other_____ Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insured's ID/SS _____

Insurance Co _____

Insurance Co Address _____

Dental Insurance Information (Secondary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insured's ID/SS _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____ Insurance Phone # _____

Group # _____Local # _____ Group #_____ Local # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

How would you rate your dental anxiety? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

Please share the following dates:

Last cleaning _____ Last oral cancer screening _____Last complete X-rays _____

What is the most important thing to you about your dental visit today?

_____

_____

Name of your previous dentist

_____Phone_____

Dental History Cont. -Please circle any of the following conditions that apply to you

Pain/Discomfort
- Sensitivity (hot, cold, sweet)
- Pressure
- Broken teeth/fillings
- Worn teeth
- Dry Mouth

Periodontal (Gum) Health
- Bleeding, Swollen, Irritated Gums
- Bad Breath
- Loose, tipped, shifting teeth
- Previous perio/gum disease

Social
- Tobacco
  How much _____ How long _____
- Alcohol Frequency _____
- Drugs Frequency _____

Previous Comfort Options
- Nitrous Oxide
- Oral Sedation (Pill)
- IV Sedation

Medical History -Please circle any of the following conditions that apply to you

Cancer
Type_____
- Chemotherapy
- Radiation Therapy

Cardiovascular
- Angina (chest pain)
- Artificial heart valve
- Heart condition
- Heart Surgery
- High/Low Blood Pressure
- Mitral Valve Prolapse
- Pacemaker
- Rheumatic Fever
- Scarlet Fever
- Stroke

Endocrinology
- Diabetes
- Hepatitis A/B/C
- Jaundice
- Kidney Disease
- Liver Disease
- Thyroid Disease

Gastrointestinal
- Ulcers (Stomach)
- Gastrointestinal Disease

Hematologic/Lymphatic
- Anemia
- Blood Disorders
- Bruise Easily
- Excessive Bleeding

Musculoskeletal
- Arthritis
- Artificial Joints
- Jaw Joint Pain
- Rheumatoid Arthritis

Neurological
- Anxiety
- Depression
- Dizziness
- Drug/Alcohol Addiction
- Fainting
- Seizures
- Psychiatric Illness

Respiratory
- Asthma
- Emphysema
- Respiratory Problems
- Sinus Problems
- Sleep Apnea
- Tuberculosis

Viral Infections
- AIDS
- HIV Positive
- HPV

Women
- Currently Pregnant
- Nursing

Medical Allergies
- Antibiotics (Amoxicillin/ Penicillin/ Clindamycin)
- Opioids (Percocet/ Oxycodone/ Tylenol 3)
- Latex
- Local Anesthetics
- NSAIDS
- Other allergies:
  _____
  _____
  _____

Are you under the care of a physician? Y or N. If yes, please explain:

_____

_____

____

Physician Name _____ Address _____ Phone (___)_____

Have you had a serious illness, operation or hospitalization in the past 5 years? Y or N. If yes, please explain:

_____

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N. If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements:

_____

_____

_____

Have you ever in the past or are you now currently taking any medication for Osteopenia/Osteoporosis or Bone Disease?
If so, please list medications:

_____

_____

Have you ever had surgery? If so, what type:

_____

_____

Consent:
The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the about terms and conditions.

_____ _____ _____
_____

Signature of Patient/Legal Guardian *Print Name* *Date* *Dentist Signature*

Payment Policy

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. Our office staff understands dental insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed dental treatment and answer any questions you might have regarding payment and your insurance plan. For the convenience of our patients we offer the following methods of payment:

- Payment in full by Cash, Check, Visa, MasterCard or Care Credit for each appointment as service is rendered. Care Credit is a method of alternative financing. We will be glad to assist you in filling out an application. Credit approval is required.
- For insurance patients: we will file a claim with your insurance company and accept payment directly from the insurance company. We gladly accept insurance payment, but require that the deductible and *estimated* co-payment be paid at the time services are rendered. An *estimate* will be given of the benefits that the insurance company is expected to pay. In the event of overpayment, you will be reimbursed.

However, it is important you realize that…

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance claim as a courtesy to you.
- Our fees generally, but not necessarily, fall within the usual and customary fee structure, determined by your carrier.
- Not all dental services are a covered benefit in all contracts. Some plans have specific exclusions. We will retrieve an insurance plan summary to better estimate your deductible and copayments. However, this summary is not a guarantee of payment by your insurance company.
- You (not the insurance company) are responsible for all our fees for services rendered to you.

Cancellation Policy

We understand that sometimes circumstances arise that prevent patients from keeping appointments. If you need to reschedule an appointment, please contact the office 48 hours in advance to avoid a charge of $50.00. With this advance notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you. We request this courtesy because it allows us to see our patients promptly and helps us provide more affordable dental care for all our patients.

I have read and reviewed the above policies. I have had the opportunity to ask any questions regarding these matters and agree to abide by the above policies.

Patient/Parent Signature: _____ Date: _____

Authorization to Release Information

McNeely Family Dentistry is authorized to release my protected health information to the entities named below:

_____ Leave information on voice mail. _____Send email or text messages

_____ Give information to the following person(s):

_____

Description of information to be released:

_____ Financial Information _____ Results from tests or x-rays

_____ Appointment Information _____ Medical Information

_____ Other Information as follows: _____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to HIPAA Officer. I understand that the information used or disclosed as a result of the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Patient/Parent Signature: _____ Date: _____