Neely AND Neely
DENTAL GROUP

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

ABOUT YOU

Today's Date _____

Email Address _____

Name _____
LAST FIRST M MR MRS MS DR

I prefer to be called _____ ❑ Male ❑ Female

Birthdate ____/____/____ Age_____ SS# _____

Home Address _____

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home (_____) _____ Cell (_____) _____

Work (_____) _____ Ext_____ DL# _____

Employer _____

Employer's Address _____

How long there?_____ Occupation _____

Where & when are best times to reach you? _____

_____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Previous / Present Dentist _____
(PLEASE CIRCLE)

Last Visit Date _____

SPOUSE INFORMATION

His/her name _____

Employer _____

Work (_____) _____ Ext_____ SS# _____

Birthdate ____/____/____ DL# _____

PERSON RESPONSIBLE FOR ACCOUNT

Work (_____) _____ Ext____ Home (_____) _____

Billing Address _____

Relation_____ SS# _____

Employer _____ DL# _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone (_____) _____

Insured's Name _____

Insured's Birthdate: _____/_____/_____ **Insured's** ID# _____

Insured's Employer: _____

Employer's Address _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone (_____) _____

Insured's Name _____

Insured's Birthdate: _____/_____/_____ **Insured's** ID# _____

Insured's Employer: _____

Employer's Address _____

IN THE EVENT OF AN EMERGENCY...

Is there someone who lives near you that we should contact?

His/her name _____

Relation _____

Work (_____) _____ Ext____ Home (_____) _____

MEDICAL HISTORY

Do you have a personal physician ❑ Yes ❑ No

Physician's Name _____

Work (_____) _____ Date of last visit _____/_____/_____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain _____

_____

– continued on back

MEDICAL HISTORY –continued

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you taking any prescription / over-the-counter or supplement drugs? ❑ Yes ❑ No

Please list each one _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No

Have you ever taken Phen-Fen? ❑ Yes ❑ No

For Women

Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #_____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following disease or medical problems?
(please circle option that applies)

Y N	Anemia / Radiation Treatment	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Bones / Joints / Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High / Low Blood Pressure
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for any reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Drug / Alcohol Abuse	Y N	Sever / Frequent Headaches
Y N	Emphysema / Glaucoma	Y N	Shingles
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers / Colitis
Y N	Heart Surgery / Pacemaker	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs / materials that you are allergic to:

_____

_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles: ❑ Hard ❑ Medium ❑ Soft

AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

_____
SIGNATURE DATE

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. **Initials** _____ **Date** _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____