PATIENT INFORMATION AND HEALTH FORM

Last Name: _____ First Name: _____ Middle Initial: _____
Preferred Name: _____ Marital Status (Please Circle): M S D
Birth Date: _____/_____/_____ Gender (Please Circle): M F
SS#: _____-_____-_____
Address: _____ City: _____ ZIP: _____
Cell Phone: _____ May We Send Text Confirmations? Y N
Email: _____ Referred By: _____
In Emergency Call(PH#): _____ Name/Relationship To You: _____
Preferred Pharmacy (Name, City, Phone #) : _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Birthdate: _____/_____/_____ SS#: _____-_____-_____
Employer: _____ City: _____
Insurance Company: _____ Insurance Phone Number: _____
Group#_____ ID#_____

I Hereby authorize payment directly to McNeeley & Shuba, DDS, Inc. of the dental benefits otherwise payable to me.

Signature: _____ Date: _____

DENTAL HEALTH HISTORY

When was your last dental visit? _____

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

If yes, please explain: _____

Do you experience dry mouth?	Y	N
Does your jaw joint (TMJ) hurt?	Y	N
Do you gag easily?	Y	N
Have you traveled outside of the U.S.A in the last 6 months?	Y	N
Do you smoke or vape?	Y	N
Do you use smokeless tobacco?	Y	N
Women: Are you pregnant?	Y	N
Do you take birth control?	Y	N
Do you take blood thinners?	**Y**	**N**

Flip ⟶

Please list any medications or over the counter drugs you take:

_____

_____

Are you allergic to any Drugs, Medications, or Latex Gloves? Y N

List Allergies: _____

Please list hospitalizations and surgeries with dates:

_____

_____

Do you have or have you had in the past any of the following:
(PLEASE CIRCLE ALL THOSE THAT APPLY)

Heart Valve Replacement
Any Artificial Joints: Hip, Shoulder, Knee, Etc.
Epilepsy/Seizures
Heart Disease
High Blood Pressure
Bleeding; Clotting Problems
Sleep Apnea/ Bariatric Surgery
Thyroid Problem
Cancer or Leukemia
AIDS/HIV Positive
Intellectual/Developmental Disability
Hepatitis A/B/C

Congenital Heart Defects
Pacemaker
Stroke
TB / Asthma / Lung Problems
Drug / Alcohol Abuse / Rehab
Diabetes: Type 1 Type 2
Sinus Trouble
Arthritis
Auto-Immune Disease
Prolonged Sore Throat or Mouth Sores
Osteopenia/ Osteoporosis
Other Conditions Not Listed: _____

_____

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. Our Privacy Practices are posted in the office, available online at mcneeleyandshubafamilydental.com, and a paper copy will be available upon request.

☐ I have been offered a written copy and I'm aware it's available at mcneeleyandshubafamilydental.com.

Signature: _____ Date: _____

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.*

Signature: _____ Date: _____