Welcome to the office of Dr. Molly McNeely

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Marital Status: Child Single Married Divorced Widowed

Mailing Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Employer: _____ SSN: _____

Person responsible for account: _____

In case of an emergency: _____ Phone: _____

How did you hear about our office? _____

Dental Insurance Information Employer: _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance Company Name: _____ Subscriber SSN: _____

Secondary Dental Insurance Information Employer: _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance Company Name: _____ Subscriber SSN: _____

Molly McNeely, DDS
Health History

What is your reason for booking this appointment? _____

When was your last dental visit? _____

Do you currently have:

dental pain	Yes	No	broken teeth/broken fillings	Yes	No
sensitive teeth	Yes	No	lumps/swelling mouth	Yes	No
tender gums	Yes	No	bleeding gums	Yes	No
bad breath	Yes	No	bad taste in mouth	Yes	No
loose teeth	Yes	No	crowded, crooked or spaced teeth	Yes	No

Do you get:

migraines or headaches	Yes	No	sinus pain or pressure	Yes	No
neck or back pain	Yes	No	earaches	Yes	No
popping/clicking in jaw joints	Yes	No	jaw joint (TMJ) pain	Yes	No

Would you like anything about your smile changed or improved?	Yes	No
Do you feel your teeth are not as white or bright as they could be?	Yes	No
Do you use tobacco products?	Yes	No

MEDICAL

Please list any medications/supplements you are taking_____

Please list any allergies you have_____

Do you have/have you had:

a bleeding disorder	Yes	No	bleed or bruise easily	Yes	No
any liver disease	Yes	No	have any lung disease	Yes	No
difficulty breathing	Yes	No	snore/gasp for breath in your sleep	Yes	No
Hepatitis (please circle) A, B, C	Yes	No	had heart surgery	Yes	No
heart disease	Yes	No	blood pressure problems	Yes	No
kidney disease	Yes	No	a shunt appliance	Yes	No
Rheumatic fever	Yes	No	take(n) anti-rejection medication	Yes	No
diabetes	Yes	No	AIDS or HIV	Yes	No
cancer	Yes	No	What kind and how long ago:_____		
radiation therapy	Yes	No	How long ago:_____		
chemotherapy	Yes	No	How long ago:_____		
an organ transplant	Yes	No	Which organ and how long ago?_____		
a joint replacement	Yes	No	Which joint and how long ago?_____		

Other than the above, have you been hospitalized and was surgery performed?	Yes	No
Have you had any serious illness?	Yes	No
Do you have any other medical conditions?	Yes	No

Have you ever taken any of the following medications? (Please Circle)
Zometa, Didronel, Fosamax, Skelid, Actonel, Aredia, Boniva, Bonefos

Women: Are you pregnant? Yes No
If yes, what month? _____
Are you breastfeeding? Yes No

Molly McNeely, DDS
Life... should be filled with smiles

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

In the event Molly McNeely, DDS may need to give your test results or dental information, may we (check all that apply)

_____ Leave a detailed message on an answering machine or with your spouse or family member.
_____ Call you on your cellular phone
_____ Call you at work
_____ Speak to you directly. **ONLY**

I_____ (DOB_____), give Dr. McNeely and staff, authorization to
(patients name here)
disclose my protected health information to the following family, friends and/or caregivers:

Name_____ Relationship:_____Phone: _____

Name_____Relationship:_____Phone: _____

Name_____ Relationship: _____ Phone: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records department.
I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

_____Date_____
Signature of Patient

OR

_____Date_____
Signature of Guardian or Personal Representative if patient is under the age of 19

Dr. Molly McNeely
1513 Central Ave
Nebraska City, NE 68410

Payment and Missed Appointment Policies

Payment is expected on the same day that the dental services are provided. As a courtesy, we will submit claims and pre-authorization for treatment to your dental insurance. We will estimate your out of pocket portion at the end of your visit and collect that portion at that time. After we hear back from your insurance, we will bill you the remaining portion if we did not figure correctly, or at the end of the month we will refund you your money for any overpayment. **Any unpaid balance is your responsibility**. We accept cash, checks, Care Credit, Visa, Discover and MasterCard. If we do need to bill you, we will expect payment within 15 days of sending out the statement. If your account goes 30 days past due, a service charge of 1.33% (16% per annum) will be added to the unpaid balance. After 90 days, if we haven't received payment, you will be contacted by phone then sent to our collection agency and any future collection will be handled by them.

Every year hundreds of hours of patient care are lost due to missed appointments. To ensure that all patients are seen in a timely manner, our practice has established a "2 strikes you're out" policy. After the 2nd missed appointment, we will dismiss you from our practice. If you are unable to make your appointment, we request that you give 48 hours' notice. Thank you for your cooperation and understanding.

I have read and understand the Payment and Missed Appointment Policies:

Signature of Patient or Guardian/Responsible party	Date	Relationship to Patient

I have read and agree with the notice of Privacy Practices for Molly McNeely, DDS (HIPPA)
If you have not heard of HIPPA and wish to read the policy, please let me know.

Signature of Patient or Legal Guardian	Date	Relationship to Patient