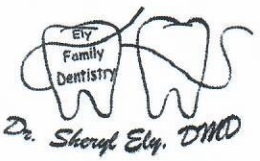

4140 NW 27th Lane, Suite H, Gainesville, FL 32606
352.373.7373 (office) - 352.377.1225 (fax) - (email:) s.elyfamilydentistry@gmail.com

Patient Name: _____ Preferred Name: _____

Date of Birth: ____/____/_____ Social Security #_____ Sex: _____ Age: _____

Driver License #: _____ State:_____

Home Address: _____Apt #:_____

City: _____ State: _____ Zip: _____

Mail/Billing Address (☐ Check box if same as Home Address)

Address: _____Apt #:_____

City: _____ State: _____ Zip: _____

Best Phone number: (_____) _____-_____ (Please circle: Cell / Home / Work)

Secondary Number: (_____) _____ - _____ (Please circle: Cell / Home / Work)

Email: _____

Circle one: Married Single Divorced Widowed Other:_____

Spouse's Name: _____ Contact number: (_____) _____ - _____

Emergency Contact Name: _____ Contact number: (_____) _____-_____

(Other than spouse)

Employer/Occupation: _____ Phone: (_____)_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Dental Insurance:

Name: _____

Subscriber Name: _____

Subscriber DOB: _____/ _____/ _____

Subscriber ID/SS#: _____

Group #: _____

Secondary Dental Insurance:

Name: _____

Subscriber Name: _____

Subscriber DOB: _____/ _____/ _____

Subscriber ID/SS#: _____

Group #: _____

Previous Dental Office Name/ Full Address/ Phone: Date of last visit:

_____ _____

Current Medical Provider Name/ Address/ Phone: Date of last visit:

_____ _____

How did you hear about us? Patient/ Google/ Facebook / Online search/ Doctor/ Website/ Ins Co./ Other

Full Name of person who referred you: _____

Ely Family Dentistry

Updated 3/14/2019

Dental History Form

Welcome to Ely Family Dentistry. We appreciate the confidence you place with us to provide your dental service. To best serve you, please complete the following form. This information is important. If you have any changes to this information, please let us know.

If you have any questions, please ask. We are here for you.

Answer options : Yes / Sometimes / No

Are you apprehensive about dental treatment? ----------Y / S / N

Have you had problems with previous dental treatment?----------Y / S / N

Are you satisfied with the appearance of your teeth?---------- Y / S /N

Do you gag easily? ----------Y / S / N

Does food catch between your teeth easily or more than preferred? ---------- Y / S / N

Do your gums bleed when you floss? ----------Y / S / N

Do your gums bleed easily?---------- Y / S / N

Do your gums feel swollen or tender? ---------Y / S / N

Do you avoid brushing any part of your mouth due to discomfort?---------- Y / S / N

Are your teeth sensitive? ---------- Y / S / N

- Hot foods or liquids---------- Y / S / N
- Cold foods or liquids---------- Y / S / N
- Sour---------- Y / S / N
- Sweet---------- Y / S / N
- Pressure---------- Y / S / N

Do you take fluoride supplements?---------- Y / S / N

How often do you floss? _____

How often do you brush? _____

Do you wear dentures or partials? ---------- Y / S / N

Do you have difficulty chewing?---------- Y / S / N

Do you chew only on one side?---------- Y / S / N

Does your jaw make noise when you open and/or close?---------- Y / S / N

Do you clench or grind your jaw frequently?----- Y / S / N

Do you have any jaw, temple pain or headaches when you wake up?---------- Y / S / N

Do you have a history of TMJ or TMD?---------- Y / S / N

Do you have pain in the face, checks, jaw, joints, throat, or temples?---------- Y / S / N

Are you aware of an uncomfortable bite?--------- Y / S / N

Have you had jaw or face trauma? ---------- Y / S / N
If yes, when? _____

Are you a habitual gum chewer or pipe smoker? Y / S / N

Would you like to know more about quitting smoking?---------- Y / S / N

Name: _____ DOB: _____/_____/_____

Last First (Preferred)

Updated 4/23/2019 Ely Family Dentistry

Medical History Form

-We understand that health history forms can be time consuming, but what goes on in your body can effect your mouth and vice versa. Please answer to the best of your ability so that we are better equipped to serve you and your needs. Thank you. -

	Yes	No		Yes	No
Heart Problems			**Endocrine Issues**		
Chest Pain			Diabetes		
Blood pressure problems			**Intestinal Problems**		
Heart murmur			Ulcers		
Heart valve problem			Special Diet		
Artificial heart valve			**Allergy Problems**		
Rheumatic Fever			Hay fever		
Pace Maker			Asthma		
Taking Heart Medication (if yes, please note in Medication List)			If yes to asthma, do you require and inhaler/have it with you?		
Bone or Joint Problems			Skin conditions/rash		
Arthritis			**Blood Problems**		
Back or Neck pain			Easy bruising		
If yes, can you lay back?			Blood disease (anemia)		
If yes, do you require a pillow?			Ever require a transfusion?		
Joint Replacement			HIV/AIDS/Hepatitis		
If yes, within the past 2 years?					
If yes, do you require pre-medication before all dental treatments?					

Have you reacted adversely to any of the following?

	Yes	No
Local anesthetics ("Novocain")		
Penicillin or other antibiotics		
Sulfa drugs		
Barbiturates, sedatives, or sleeping pills		
Aspirin, Acetaminophen, or Ibuprofen		
Codeine, Demerol, or other narcotics		
Latex or rubber dam		
Allergy not listed above:		

Women	Yes	No
Are you taking contraceptives or other hormones?		
Are you pregnant?		
If yes, what trimester?		
Expected delivery date?		

Office Use Only

BP: _____/_____ P: _____

Office Use Only

Last Cleaning: _____ Concerns: _____

_____ _____

_____ _____

Name: _____ DOB: ____/____/____

Last First (Preferred)

Medication List

This side office use only:

Medication Name	**Started** / **Stopped**	

Pt Name: _____ DOB: _____/_____/_____

Created Date: _____/_____/_____

ELY FAMILY DENTISTRY
DR. SHERYL ELY
4140 NW 27TH LN. SUITE H
GAINESVILLE, FL 32606

HIPAA CONSENT FORM:

I understand that under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers Who may be involved in that treatment directly and in-directly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your "Notice of Privacy Practices" containing a more complete Description of the uses and disclosures of my health information. I have been given the right to review Such "Notice of Privacy Practices" prior to signing this consent. I understand that this organization has the right to change its "Notice of privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

With your consent is it ok to contact you regarding your dental treatment and account through:

Phone Number: YES or NO if yes please provide number:_____
Is it ok to leave a detailed message on your voicemail: YES or NO

Email: YES or NO if yes please provide email:_____

Patient Name_____

Signature _____

Date _____

Financial Policy

Thank you for choosing Dr. Sheryl Ely and Ely Family Dentistry as your dental care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we ask that your read. Payment in full is expected at the time of your service, unless you have made Prior arrangements with our office administrator.

We want you to receive the full benefit from your insurance policy. Because the policy is an arrangement between you and your carrier, you are responsible for any remaining balance that your insurance does not cover.

We require a 48-hour notice to reschedule and avoid a fee. There will be an automatic $50.00 fee assessed to all patients who fail to keep their scheduled appointment without time required notification. This fee is also assessed to Same Day cancellations as it is considered a Broken Appointment.

****Appointments scheduled for Monday must be cancelled on the Wednesday prior to fill the void that has been created once the appointment(s) has been rescheduled or cancelled****

We accept payment in the form of cash, Visa, Mastercard, or check (returned check fee of $35.00)

As a service to all our patients, we are pleased to offer a dental plan through CareCredit. With CareCredit you can finance up to 100% of your procedure cost with little to no interest (within a certain time frame of payment). *Available to approved applicants*

We realize that everyone's financial situation is different, for this reason we have provided a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

Signature: _____ Date: _____

Print Name: _____

Ely Family Dentistry

4140 NW 27th Lane, Suite #H

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(352) 373 - 7373