website: www.taylordentalcare.net

Taylor Dental Care

PATIENT INFORMATION FORM

PATIENT_____ Email Address:_____
Address_____ City_____ State_____ Zip_____
Home Phone:_____ Cell Phone: _____
Preferred way to contact: Home Phone: ☐ Email: ☐ Cell Phone: ☐ Text Messages: ☐
Date of Birth_____ Social Security Number_____
If student, grade_____ School/College _____

RESPONSIBLE PARTY_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Employer_____ Occupation _____ Work Phone_____ Ext._____
Relation_____ Social Security Number_____ Date of Birth_____

SPOUSE_____ Social Security Number_____
Address _____ City_____ State_____ Zip _____
Spouse's Employer_____ Work Phone _____ Date of Birth_____
Cell phone: _____

Whom may we thank for referring you?_____

Whom may we contact in the event of an emergency?_____

Relationship_____ Home Phone _____

Previous Dentist_____ Last Visit _____

Insurance Company (1) _____ Subscriber_____

Group Number_____ I.D. Number_____

Insurance Company (2) _____ Subscriber_____

Group Number_____ I. D. Number _____

I WILL BE PAYING TODAY BY: Cash ☐ Check ☐ Credit Card ☐ (Please check one)

I agree that I am ultimately responsible for any account balance for services rendered. I certify that the above information is true and correct to the best of my knowledge. In the event that my account has to be referred for collection, I agree that I am responsible for any and all costs of collection fees, which is 33.33% of the balance, or legal fees, which may be up to 50% of the amount due. I acknowledge that I have read and understand the terms of this agreement.

Responsible Party's Signature_____ Date_____

I hereby give authorization that all third-party payments of my/our dental benefits (Insurance, etc.) otherwise payable to me or my family be made directly to Donald L. Taylor, Jr. D.D.S.

Responsible Party's Signature_____ Date_____

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Dr. Donald L. Taylor, Jr. D.D.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____ have reviewed or received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name Here

_____

Signature

_____

Date

This office may release information to the named persons;

_____

_____

_____

_____

For Office Use Only

_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

☐ Individual refused to sign.
☐ Communication barriers prohibited obtaining the acknowledgment.
☐ An emergency situation prevented us from obtaining acknowledgment.
☐ Other (Please Specify)

_____

_____

_____

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PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

	Yes	No
1. Are you under any medical treatment now?	☐	☐
2. Have you had any major operations?	☐	☐
If so, what? _____		
3. Have you ever had a serious accident?	☐	☐
4. Do you have or have you had any of the following diseases?		
a. Rheumatic fever or Rheumatic heart disease	☐	☐
b. Congenital heart lesions	☐	☐
c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, heart murmur, palpitations)	☐	☐
d. Emphysema, asthma, or hay fever	☐	☐
e. Hives or skin rash	☐	☐
f. Fainting spells or seizures	☐	☐
g. Diabetes	☐	☐
h. Hepatitis, jaundice, liver disease	☐	☐
i. Arthritis, inflammatory rheumatism (painful swollen joints)	☐	☐
j. Stomach ulcers or intestinal problems	☐	☐
k. Kidney trouble	☐	☐
l. Tuberculosis, persistent cough or coughing up blood	☐	☐
m. High or low blood pressure	☐	☐
n. Venereal or sexually transmitted diseases	☐	☐
o. Allergies	☐	☐
p. Tumors, growths, or cancers	☐	☐
q. AIDS or have tested positive to HIV	☐	☐
5. Do you have pain in the chest upon exercise?	☐	☐
6. Are you ever short of breath after mild exercise	☐	☐
7. Do your ankles swell?	☐	☐
8. Do you get short of breath when you lie down, or do you require extra pillows when you sleep?	☐	☐
9. Do you have to urinate (pass water) more than six times a day?	☐	☐
10. Does your mouth frequently become dry?	☐	☐
11. Are you thirsty much of the time?	☐	☐
12. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	☐	☐
a. Do you have any blood disorders?	☐	☐
b. Do you bruise easily?	☐	☐
c. Have you ever required a blood transfusion?	☐	☐
13. Are you taking any of the following?		
a. Antibiotics or sulfa drugs	☐	☐
b. High blood pressure medicine or anticoagulants (blood thinners)	☐	☐
c. Cortisone (steroids)	☐	☐
d. Tranquilizers	☐	☐
e. Aspirin, anacin, bufferin	☐	☐
f. Insulin, tolbutamide (orinase) or similar drug	☐	☐
g. Nitroglycerin, digitalis, or drugs for heart trouble	☐	☐
h. Birth control pills	☐	☐
i. Bisphosphonates (osteoporosis/Cancer drugs) ex. Zometa, Aredia, Fosamax	☐	☐
j. Other	☐	☐
14. Are you allergic or have you reacted adversely to:		
a. Local anesthetics	☐	☐
b. Sulfa drugs, penicillin, or other antibiotics	☐	☐
c. Barbiturates, sedatives or sleeping pills?	☐	☐
d. Aspirin	☐	☐
e. Codeine or other narcotics	☐	☐
f. Other?	☐	☐
15. Do you use alcohol or other recreational drugs on a daily/weekly basis	☐	☐
16. Are you employed in any situation which exposes you regularly to x-rays or other Ionizing radiation?	☐	☐
17. Are you pregnant?	☐	☐
18. Do you have any diseases, conditions or problems not listed above that you think I should know about?	☐	☐

Signature: _____