



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 _____

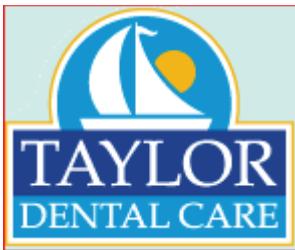
I WILL BE PAYING TODAY BY: Cash Check Credit Card (Please check one)

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

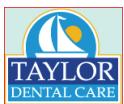
Date

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)



PATIENT MEDICAL HISTORY

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

Signature: _____