

Donald L. Taylor, Jr., D.D.S.
PATIENT INFORMATION FORM

PATIENT _____ Age _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

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 _____

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 _____

PATIENT MEDICAL HISTORY

Name: _____

Date: _____

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

Signature: _____

over

web site: www.taylor-dental-care.net

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)

