Taylor Family Dental

Dr. Randy K. Taylor, DMD – Dr. Richard L. Vonnahme, III, DMD – Dr. Anna M. Jayjock, DMD

Patient Information

Name____ Preferred Name __________________ [ ] Male [ ] Female
First MI Last

SS#____________________ Birth Date______________Status [ ] Single [ ] Married [ ] Child [ ] Divorced [ ] Widowed

Address____City_________________State______Zip_________

Home Phone ____________________Cell Phone____________________Email_________________________________

Employer Name & Address____Work Phone: _____________

Spouse or Parent/Guardian's Name____ Birth date: _________________

Spouse or Parent/Guardian's Employer ____ Work Phone: _____________

Whom may we thank for referring you? ____

Other family members seen in our office ____

*Emergency Contact____ Phone: _________________________

Account Information - Responsible Financial Party

Person Responsible for Account _______________________________________ [ ] Self [ ] Spouse [ ] Mother [ ] Father

Address____City________________State_______Zip___________

Best Phone #_________________Email___________________________________Birth Date_____________________

We offer the following payment methods. Please check the option you prefer. **Payment is due in full at time of service.**

[ ] Cash [ ] Personal Check [ ] Credit Card (all major cards accepted) [ ] Care Credit

Dental Insurance Information

Primary Dental Insurance

Insurance Company___________________________________Phone #_______________Group No._________________

Insured's Name________________________________Birth Date ____________ Insured's Employer_________________

Insured's SS# or Policy ID# _______________________ Relationship to Patient_________________

Secondary Dental Insurance

Insurance Company___________________________________Phone #_______________Group No._________________

Insured's Name________________________________Birth Date ____________ Insured's Employer_________________

Insured's SS# or Policy ID# _______________________ Relationship to Patient_________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I accept full responsibility for all treatment performed by the doctors and dental staff. I authorize the release of any information concerning my (or my dependents') healthcare, advice or treatment provided for the purpose of evaluating and administering insurance claims for benefits or to another dentist. I authorize and request my insurance company to pay directly to Taylor Family Dental PLLC insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. **I am financially responsible** for payment of all services rendered on my behalf or my dependents.

Signature____ Date______________________

Notice of Privacy Practices and Acknowledgement

Our Notice of Privacy Practices provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your PHI. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given an opportunity to ask question I may have regarding this notice.

Signature____ Date______________________

Protected Health Information (PHI)

I authorize the following person(s) to have access to my protected heath information.

Name:____

Name:____

Signature ______________________________________ Date ____________________________

If minor,

Parent/Guardian Name:_____________________________________Relationship to Patient:__________________

Appointments

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

Financial Policy

Payment is due at time of service. We file dental insurance as a courtesy to our patients. Any estimated insurance portions, determined by information provided to us, are payable at time of service. To assist you with your dental needs, we provide the following payment options: Cash, Check, All Major Credit Cards and Care Credit Financing. Please feel free to direct any questions to our office staff. A fee of $25.00 will be charged per returned check.

Medical History

Patient Name ______________________________________ Birthdate _____________Today's Date ______________

Please indicate any condition that you have had in the past or have now by checking those that apply:

[ ] Angina / Chest Pain
[ ] Artificial Heart Valve
[ ] Heart disease or attack, Type ________
[ ] Heart Surgery, Type ___________
[ ] Pace Maker
[ ] High Blood Pressure
[ ] Irregular Heartbeat (arrhythmia)
[ ] Mitral Valve Prolapse
[ ] Rheumatic Fever
[ ] Heart Disorder (congenital)
[ ] Stroke, When _____________

[ ] Asthma
[ ] Emphysema / COPD
[ ] Sinus Problems
[ ] Tuberculosis (TB)
[ ] Breathing Problems, Type _______

[ ] Kidney Problems, Type _________
[ ] Dialysis

[ ] Diabetes, Type _______
[ ] Thyroid Disease/Problems

[ ] Arthritis
[ ] Artificial Joint, Type __________

[ ] Sexually Transmitted Disease
 [ ] HIV/AIDS
 [ ] Other____________
[ ] Tobacco Use
[ ] Drug Addiction (past/present)
[ ] Tumor or Cancer, Type __________
[ ] Radiation Treatment, When ______
[ ] Chemotherapy, When _________

[ ] Anemia
[ ] Sickle Cell Disease
[ ] Excessive bleeding/Blood thinners

[ ] Stomach Ulcers
[ ] Acid Reflux
[ ] Hepatitis, Type________
[ ] Liver Disease or Jaundice

[ ] Fainting
[ ] Dizziness
[ ] Epilepsy/Seizures
[ ] Migraine Headaches
[ ] Anxiety/Nervousness
[ ] Psychiatric Treatment/Mental Disorder
[ ] Glaucoma
[ ] Vision problems, Type __________
[ ] Hearing loss

ALLERGIES:
[ ] Aspirin
[ ] Penicillin
[ ] Codeine
[ ] Local Anesthetics
[ ] Latex
[ ] Epinephrine Sensitivity
[ ] Other _______________

Do you have any health problems that were not listed above? Do any of the above need further clarification?

If yes, explain:____

Please list any past surgeries and dates: ____

Have you been admitted to a hospital or needed emergency care during the past 2 years?

If yes, explain: ____

Have you traveled outside the United States during the past 2 years? If yes, where and when? _______________________

Women (please check if applicable): [ ] pregnant [ ] trying to get pregnant [ ] nursing [ ] taking oral contraceptives

Have you ever taken any bisphosphonate medications? [ ] Yes [ ] No [ ] Unsure

If so, when? _____________________ (Brands include Actonel, Boniva, Fosamax, Reclast, Aredia, Didronel, & Zomets)

Medications ***Please list any medications, drugs, or supplements you are currently taking***: ________________________

____

Physician's Name: ____ Phone Number:______________________

Dental History

When was your last dental visit? ____/____/____ How often do you have your teeth cleaned? ______________________

Please indicate any of the following conditions that apply:

[ ] Gums bleeding when brushing
[ ] Loose teeth / broken fillings
[ ] Frequent dry mouth
[ ] Clenching or grinding of teeth

[ ] Clicking or popping jaw joint
[ ] Gag easily
[ ] Have ever worn braces
[ ] Mouth sores/ulcers/blisters

[ ] Tooth pain or sensitivity to:
 [ ] Biting or Chewing [ ] Hot
 [ ] Sweets [ ] Cold

Are you happy with your smile? Y/N