



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 health 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema / COPD | <input type="checkbox"/> Artificial Joint, Type _____ |
| <input type="checkbox"/> Heart disease or attack, Type _____ | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Surgery, Type _____ | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Breathing Problems, Type _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems, Type _____ | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Irregular Heartbeat (arrhythmia) | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Drug Addiction (past/present) |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Diabetes, Type _____ | <input type="checkbox"/> Tumor or Cancer, Type _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease/Problems | <input type="checkbox"/> Radiation Treatment, When _____ |
| <input type="checkbox"/> Heart Disorder (congenital) | | <input type="checkbox"/> Chemotherapy, When _____ |
| <input type="checkbox"/> Stroke, When _____ | | |
-
- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | ALLERGIES: |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Excessive bleeding/Blood thinners | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Penicillin |
| | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Psychiatric Treatment/Mental Disorder | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Hepatitis, Type _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Epinephrine Sensitivity |
| <input type="checkbox"/> Liver Disease or Jaundice | <input type="checkbox"/> Vision problems, Type _____ | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Hearing loss | |

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Gums bleeding when brushing | <input type="checkbox"/> Frequent dry mouth | |
| <input type="checkbox"/> Loose teeth / broken fillings | <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> 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

