Taylor Family Dental

Dr. Randy K. Taylor, DMD – Dr. Richard L. Vonnahme, III, DMD – Dr. Anna M. Jayjock, DMD
Dr. Christian E. Duncan, 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, **3.5% Service Fee**) [ ] 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 certifythat 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 questions 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 with 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 (subject to 3.5% Service Fee) 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.

Consent for Dental Treatment

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ 1. DRUGS AND MEDICATIONS:
I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea, vomiting or more severe allergic reactions. I have informed the doctors of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 2. RISKS OF DENTAL ANESTHESIA:
I understand that pain, bruising, and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue, or associated facial structure can occur with "shots." About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possible treatment may be needed if symptoms do not resolve.

_____ 3. CHANGES IN TREAMENT PLAN:
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgement to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to change.

Signature_____ Date_____

Consent for E-mail and Text Messaging

Taylor Family Dental, PLLC and our respective contractors on our behalf, may utilize the contact information you have provided to us to send you information including appointment reminders, appointment availabilities, direct communications, and promotional messages.

By providing your contact information, including your cellular phone number and email, you request and give express written consent to receive communications through text messages to your cellular phone number using an automated telephone dialing system and to the email listed. You understand that text messages and/or emails are not encrypted (i.e., secure) which means it is possible they could be viewed or accessed by others. Your consent means you agree to receive unsecure text and email messages and understand the risks. Message and data rates from your carrier may apply for text messages.

I understand I may revoke my consent at any time. You may reply [STOP] to stop receiving text messages on your cellular phone. Please call our office if you wish to stop receiving emails. Your consent to receive communications by text and/or email is not required in order to receive treatment or services offered by us.

Signature_____ Date_____

Medical History

Patient Name _____ Birthdate _____ Today's Date _____

Please indicate any condition that you <u>have had in the past</u> or <u>have now</u> 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
[ ] Sulfa
[ ] 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 <u>2 years</u>?

If yes, explain: _____

Have you traveled outside the United States during the past <u>2 years</u>? If yes, where and when? _____

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

Have you <u>ever</u> taken any bisphosphonate medications? [ ] Yes [ ] No [ ] Unsure

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

<u>Medications</u> ***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/