



Taylor Family Dental

Dr. Randy Taylor, DMD Dr. Richard Vonnahme III, DMD

Whom may we thank for referring you? _____

Other family members seen in our office _____

Patient/Spouse Information

Name _____ Preferred Name _____ [] Male [] Female

SS# _____ Birth date _____ Status [] Single [] Married [] Child [] Other

Address _____ City _____ State _____ Zip _____

Best Phone # _____ Email Address _____

Employer Name & Address _____ Work Phone: _____

Spouse _____ Birth date: _____ SS# _____

Spouse Employer & Address _____ Work Phone: _____

*Emergency Contact _____ Phone: _____

Responsible Party

Name of Person Responsible _____ Relation _____

Address _____ City _____ State _____ Zip _____

Phone # _____

Insurance Information

Primary Insurance

Insurance Co. Name _____ Phone # _____ Group/Policy # _____

Insured's Name _____ Birth date _____ Relationship _____

Insured's SS # _____ Insured's Employer _____

Secondary Insurance

Insurance Co. Name _____ Phone # _____ Group/Policy # _____

Insured's Name _____ Birth date _____ Relationship _____

Insured's SS # _____ Insured's Employer _____

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 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 agree to be and am responsible for payment of all services rendered on my behalf or my dependents. A Fee of \$25.00 will be charged per returned check.

Signature _____ Date _____

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.

* Subject to Credit approval.

Notice of Privacy Practices and Acknowledgement

It is the policy of our practices that:

- We will provide a copy of the Notice of Privacy Policies to all patients regardless of whether they sign a Patient Consent Form.
- The Privacy Officer is responsible for ensuring that appropriate education and procedures are in place and enforced to assure senior management that Patient Consent Forms are being obtained and handled properly and in accordance with our policies and the relevant statutes.

(include the following if you determine that as a practice you want to obtain a signed consent from your patients on a voluntary basis)

As a practice we have determined that it is in the best interest of our patients and our practice to voluntarily obtain a signed consent form and, as such, we adopt the following practices, understanding that we will not withhold treatment or other patient services if a signed consent form is not obtained by the patient:

- We will obtain a properly signed and dated Patient Consent form from each patient.
- We will not discriminate in treating patients based on their agreement or lack thereof in regards to the Patient Consent Form.
- We will maintain Patient Consent Forms on file for 6 years after their last effective use.

Violation of the policies can carry serious consequences for the practice. Disciplinary actions for anyone violating this policy may include suspension without pay or termination.

Signature _____ Date _____

Medical History

Physician's Name: _____ Phone Number: _____

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"/> Tuberculosis (TB) | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Breathing Problems | |
| <input type="checkbox"/> Heart disease/attack | | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Heart Disorder (Congenital) | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Drug Addiction (past/present) |
| <input type="checkbox"/> Heart Surgery | | <input type="checkbox"/> Tumor or Cancer |
| <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemotherapy |
| | <input type="checkbox"/> Thyroid Disease/Problems | |
| <input type="checkbox"/> Anemia | | ALLERGIES: |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Penicillin |
| | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other _____ |

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

If yes, explain: _____

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

If yes, explain: _____

Please list any medications you are currently taking: _____

WOMEN (please check): pregnant trying to get pregnant nursing taking oral contraceptives

Dental History

When was your last dental visit? ___/___/___ How often do you have your teeth cleaned? _____

Do your gums bleed when you brush your teeth? Y / N Have you ever worn braces? Y / N

Do you grind or frequently clench your teeth? Y / N Are you happy with your smile? Y / N

Do you have frequent dryness of the mouth? Y / N

Are any of your teeth painful when biting or chewing? Y / N

Do you gag easily or do you have a problem with gagging during dental treatment? Y / N

When opening and closing your mouth, do you experience clicking, popping or grinding? Y / N

To the best of my knowledge, the stated responses are correct and true. If there are any changes in my health history, I will inform the dentist at the next appointment.

Patient's Signature

Signature of Parent or Legal Guardian

Date