Taylorview Dental

Patient Information

NAME (Last, First): _____ Preferred Name: _____

SEX: ☐ Male ☐ Female ☐ Decline to answer DATE OF BIRTH: _____

ADDRESS: _____ CELL PHONE #: _____

_____ HOME PHONE #: _____

PATIENT'S SS #: _____ PATIENT'S E-MAIL: _____

Person responsible for this account: _____ Contact #: _____

Best way to contact you (mark all those apply): ☐ Cell ☐ Home ☐ Text ☐ E-mail

Can we send appointment reminder's via TEXT MESSAGE? ☐ YES ☐ NO

Emergency Contact outside of house: _____ Relationship: _____

Emergency Contact's phone number: _____

Who May we Thank for Referring You: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Your Work #: _____

Spouse's Employer: _____ Spouse's SS #: _____

Primary Insurance Coverage:

Insurance Company: _____ Group Policy Number: _____

Insurance Company's Address: _____ Insurance Company's Phone #: _____

Insured's Name: _____ Relation: _____ Insured's Phone Number: _____

Insured's Birth Date: _____ Insured's SS #: _____ Insured's Employer: _____

Secondary Insurance:

Insurance Company: _____ Group Policy Number: _____

Insurance Company's Address: _____ Insurance Company's Phone #: _____

Insured's Name: _____ Relation: _____ Insured's Phone Number: _____

Insured's Birth Date: _____ Insured's SS #: _____ Insured's Employer: _____

To the best of my knowledge the information on this form has been answered accurately. I understand that I am financially responsible for all services and fees incurred and that accounts over 90 days are subject to a finance charge that may be calculated at a monthly rate of 1% per month. I understand that any insurance benefits quoted are only estimates and that I am responsible for all services rendered. I authorize all insurance benefits to be paid directly to Taylorview Dental and I further release any information required to process insurance claims. If I fail to keep my appointment and have not called to cancel or reschedule within 24 hours I agree to pay a $25 missed appointment fee. Taylorview Dental is in compliance with HIPPA regulations and I have been given the opportunity to review and/or receive a copy of the HIPPA regulations.

Printed Name: _____ **Date:** _____

Patient's Signature (or legal guardian):

_____

TAYLORVIEW DENTAL MED HX

Patient Name: **Birth date:** **Today's Date:**

Please Answer the following questions below by circling YES or NO

Are you under a physician's care now?	Yes	No	If yes, explain
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, explain
Have you ever had a serious head or neck injury?	Yes	No	If yes, explain
Are you taking any medications, pills or drugs?	Yes	No	If yes, explain
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, explain
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes, explain
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	If yes, explain

Women: are you.... ☐ Pregnant/Trying to become pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you ALLERGIC to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codiene ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other _____

Do you have or have you ever had any of the following: (please circle YES or NO)

AIDS/HIV positive	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina	Yes	No
Arthritis/Gout	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No
Asthma	Yes	No
Blood Disease	Yes	No
Blood Transfusion	Yes	No
Breathing Problems	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Chemotherapy	Yes	No
Chest Pains	Yes	No
Cold Sores/Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Convulsions	Yes	No
Yellow Jaundice	Yes	No

Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Easily Winded	Yes	No
Emphysema	Yes	No
Epilepsy or Seizures	Yes	No
Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No
Fainting Spells/Dizziness	Yes	No
Frequent Cough	Yes	No
Frequent Diarrhea	Yes	No
Frequent Headaches	Yes	No
Genital herpes	Yes	No
Glaucoma	Yes	No
Hay Fever	Yes	No
Heart Attack/Failure	Yes	No
Heart Murmur	Yes	No
Heart Pacemaker	Yes	No
Heart Trouble/Disease	Yes	No

Hemophilia	Yes	No
Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Hives or Rash	Yes	No
Hypoglycemia	Yes	No
Irregular Heartbeat	Yes	No
Kidney Problems	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Lung Disease	Yes	No
Mitral Valve Prolapse	Yes	No
Osteoporosis	Yes	No
Pain in Jaw Joints	Yes	No
Parathyroid Disease	Yes	No
Psychiatric Care	Yes	No

Radiation Treatments	Yes	No
Recent Weight Loss	Yes	No
Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No
Rheumatism	Yes	No
Scarlet Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Spina Bifida	Yes	No
Stomach/Intestinal Disease	Yes	No
Stroke	Yes	No
Swelling of Limbs	Yes	No
Thyroid Disease	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumors or Growths	Yes	No
Ulcers	Yes	No
Venereal disease	Yes	No

Have you ever had any serious illness not listed above ☐ YES ☐ NO

- If Yes please explain

Any additional comments:

Taylorview Dental

Acknowledgment of Receipt of Notice of Privacy Practices

Please Read and Initial the Following

1. I am aware of Taylorview Dental's Notice of Privacy Practices. Initial _____
2. I agree to the open treatment area used by Taylorview Dental and understand a private treatment area may not be available. Initial _____
3. I agree and understand that other patients will be completing treatment plans during my visit and may overhear information regarding my plan of care. Initial _____
4. I agree that Taylorview Dental employees may call my home/cell phone in regard to my dental health. Initial _____
5. I agree to let Taylorview Dental send me notifications/reminders via text message. Initial _____

_____ _____

Patient/Guardian Signature Today's Date

This Section is for Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual Refused to Sign

_____ Communication barriers prohibited obtaining acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (please specify) _____

Taylorview Dental

Financial Agreement

I understand that I am financially responsible for all services and fees incurred and that accounts over 90 days are subject to a finance charge that may be calculated at a monthly rate of 1% per month.

Initials: _____

I understand that any insurance benefits quoted are ONLY ESTIMATES and that I am responsible for all services rendered. I authorize all insurance benefits to be paid directly to Taylorview Dental and I further release any information required to process insurance claims.

Initials: _____

If I fail to keep my appointments and have not called to cancel or reschedule within 24 hours, I agree to pay a $50 missed appointment fee.

Initials: _____

Printed Name: _____

Signature: _____ Date: _____

****This form is valid for ALL patients on family accounts (parent's and dependents)**

Taylorview Dental

AUTHORIZATION TO RELEASE MEDICAL AND DENTAL INFORMATION TO FAMILY MEMBER(S), GUARDIAN, AND OTHERS

First & Last Name of Patient: _____
Date of Birth: _____

I hereby authorize dental providers and personnel of Taylorview Dental to discuss and/or release my protected health information with: (Please note that if patient is a minor, each parent or guardian needs to be listed.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that Taylorview Dental has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient