Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: _____ Social Security #: _____

Phone to contact during business hours: _____ Text capable phone: _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Person _____
Name Phone #

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints-Knee, Hip
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Thinner
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Free Bleeder
- ☐ Growths or Tumors
- ☐ Head Injuries
- ☐ Heart Disease or Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Mental or Nervous Disorders
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy:Due Date
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco User
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Latex Allergy
- ☐ Other Drug Allergies _____

Do you require PRE MED w/antibiotics prior to dental treatment? _____

Please list all medications you are currently taking including prescriptions, over the counter medications and/or herbal remedies:

_____

Have you ever had Chemotherapy (Oral or IV) ☐ Yes ☐ No
If yes, please explain reason for treatment with approximate date and medications. We are specifically interested if you had any bisphosphonates: _____

Have you ever taken any medication for Osteoporosis or Bone Loss (Oral or IV). These medications could include, but not limited to Actonel, Boniva, Didronel, Fosamax, Fosamax Plus D, Aredia, Bonefos, or Zometa ☐ Yes ☐ No
If yes, please explain: _____

Have you ever taken any medication for Acid Reflux, Heartburn, or GERD. These medications could include, but not limited to Nexium, Prevacid, Protonix, Pepcid, Tagamet, Zantac, or Axid ? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Dental Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ SSN #: _____ Group #: _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

HIPPA AUTHORIZATION

S. D. Taylor, DDS and staff is authorized to release protected health information about the above named to the entities below:

Initial each that is subject to this authorization.

_____Leave information on voice mail
_____Give information to spouse
_____Financial information
_____Information results from x-rays
_____Family billing information

Rights of the patient

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to S. D. Taylor DDS.

I understand that revocation is not effective in cases where the information has already been disclosed but will be effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected under Federal Law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____Date_____
Signature of Patient and or Guardian

TAYLOR FAMILY DENTISTRY

"Your Raleigh Dentist" Steven D. Taylor, DDS