PATIENT RECORD

Date_____

Patient's Last Name_____ First Name_____ MI_____

Patient's Date of Birth_____ Age____ Sex ___ Social Security#_____

Patient's Address_____

Phone Number _____ Email Address _____

Spouse or Legal Guardian Last Name_____ First_____

Emergency Contact Name and Phone Number_____ Relationship_____

How did you learn about us? _____ Whom can we thank for a referring you? _____

Reason for visit? _____

Last dental visit? _____

MEDICAL RECORD

Please mark X to indicate if you have or have had any of the following

___Heart Disease	___Anemia	___Heart pacemaker
___Angina	___Asthma/Hay Fever	___Congenital Heart Lesions
___Stroke	___High/Low Blood Pressure(circle)	___Ulcers
___Lung Disease	___Diabetes	___Sinus Trouble
___Cancer (Type)_____	___Radiation	___Chemotherapy
___Jaundice	___Epilepsy	___Hepatitis (circle) A B C
___Arthritis	___Glaucoma	___Herpes
___AIDS	___Tuberculosis	___COPD
___HIV Positive	___Crohn's Disease	___Other

Medical Allergies

Antibiotics___ Which ones? _____ Local Anesthetics___ Which ones? _____

Opioids____ NSAIDS____ Other____ Explain _____

Physician Name & Address_____ Phone_____

List Current Medications_____

Do you need antibiotics prior to treatment? Yes ___ No___ Reason _____

Is there anything concerning your past or present medical or dental history which you feel the doctor should know? Y___ N___
Describe _____

Have you ever had a serious illness, operation or hospitalization Yes___ No ___
Explain (if yes) _____

Have you ever been treated with radiation therapy? Y___ N___ When? _____

Are you subject to prolonged bleeding? _____

Are you subject to fainting spells? _____

Do you have excessive urination and/or thirst? _____

Do your gums bleed while brushing? _____

Do you avoid brushing any part of your mouth because of pain? _____ What part? _____

Do you chew on only one side of your mouth? _____ Which Side? _____

Do your gums feel tender or swollen? _____

Do you clench or grind your jaw while sleeping or during the day? _____

Do you wear dentures or partials? _____ What year were they made? _____

Have you ever had any serious problems associated with previous dental treatment? Y____ N____
Explain _____

WOMEN

Are you or is there a possibility of pregnancy? Y or N How far long? _____

Are you nursing? Y or N

_____

I certify that I have read, understood, and personally reviewed the above questions and answers and that to the best of my knowledge, they are true and correct. If I ever have a change in my health, or my medications change, I will inform the Doctor of Dentistry on the next appointment without fail.

_____
Signature

***If Patient is a minor, person responsible for account:

Name: _____ Signature: _____

FAMILY and FINANCIAL INFORMATION

Person Responsible for Account:

Name_____
(Last) (First) (Middle)

Address_____
(Street) (City) (State) (Zip)

Phone Number (Home/Cell)_____ Business Phone_____

Email Address_____Employer_____

Do you have Dental Insurance that you want us to file? _____

AUTHORIZATION OR CARE/RELEASE OF INFORMATION AND ASSIGNMENT

I accept full responsibility for the treatment performed by this office. Payment to the Doctor of Dentistry is expected at the time of service, unless other arrangements are made.

I agree to pay all applicable charges for any and all family members who appear for treatment at any time, which are not paid in full by assigned insurance. If amounts due to the healthcare providers are not paid after reasonable notice, the account shall be deemed delinquent and a monthly finance charge shall be added to the amount due. In the event that I default on the payment of my account, I understand that I'm responsible for any and all costs incurred in the collection of my account including court and reasonable attorney fees. If the debt is assigned to a third party for collections, I agree to be responsible for collection fees of 30% and interest due to amounts in default.

If you have dental insurance, we will be happy to assist you in processing your claims for the benefits to which you are intitled. You must realize that your insurance company has an obligation to you and not to the dentist. This office has no contractual arrangement with insurance carriers or unions.

I hereby authorize any insurance carrier with whom I have a policy to pay directly to the provider any benefits otherwise payable to me. I hereby transfer and assign the benefits of any policies of insurance to those dental providers who have rendered services to me, and those covered under my dental plan, and who accept such assignment.

*PAST DUE ACCOUNTS subject to a 1.75% monthly finance charge

_____ _____
(Signature) (Date)

_____
(Relationship to Patient, if Minor)

++Please list all members (first and last name) covered under your dental insurance plan and for whom you agree to pay uninsured balances:

_____

Joseph Meek, DDS, PC; Beau V. Taylor, DDS, PC; Julia Santi, DDS; Gary V. Taylor, DDS, PC

INFORMED CONSENT FOR DENTAL TREATMENT

1. **EXAMINATION AND X-RAYS**

   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. **DRUGS, MEDICATION AND SEDATION**

   I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any prescription medications and drugs that may have been given to me in the office for my care. I understand that failure to take prescribed medications for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effects treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **CHANGES IN TREATMENT PLAN**

   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any or all changes and additions as necessary.

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**

   I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, thein I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. **FILLINGS**

   I understand that care must be exercised in chewing on fillings to avoid breakage. I understand that sensitivity is a common after-effect of a newly placed filling.

6. **REMOVAL OF TEETH**

   Alternatives to tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any other necessary for reasons in paragraph #3. I understand removing teeth removing teeth does not always remove all the infection if present and it may be c=necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, damage to other teeth, tongue, and surrounding tissue(paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. **CROWNS, BRIDGES, VENEERS AND BONDING**

   I understand that sometimes it is not possible to match the color of artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be done before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for further root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily procedures.

8. **DENTURES-COMPLETE OR PARTIAL**

   I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of =wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be “teeth in wax” try0in visit. I understand that most dentures require realigning approximately three to twelve months after placement. The cost for this procedure is not the initial denture fee.

9. **ENDODONTIC TREATMENT (ROOT CANAL)**

   I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. **PERIODONTAL TREATMENT**

    I understand that if I have a serious condition causing gum inflammation and/or bone loss that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

I understand that dentistry is not an exact science therefore; reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for mu dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____

JOSEPH R. MEEK, DDS, PC
BEAU V. TAYLOR, DDS, PC
JULIA C. SANTI, DDS
GARY V. TAYLOR, DDS, PC

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Beau V. Taylor, DDS, PC and Joseph R. Meek, DDS, PC to use and disclose health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). {Beau V. Taylor, DDS, PC has a "Notice of Privacy Practices" which provides a more complete description of such uses and disclosures.}

I have the right to review the "Notice of Privacy Practices" prior to signing this consent. Beau V. Taylor, DDS, PC and Joseph R. Meek, DDS, PC reserves the right to revise the "Notice of Privacy Practices" at any time. A revised "Notice of Privacy Practices" may be obtained upon your request.

With this consent, Beau V. Taylor, DDS, PC and Joseph R. Meek, DDS, PC may call my home (or other alternative location) to leave a text/sms message, a voicemail message or may communicate the message in person. These calls would be in reference to any item(s) that assists the practice in carrying out TPO such as appointment reminders, insurance items and other calls pertaining to my clinical care.

I have the right to request that Beau V. Taylor, DDS, PC and Joseph R. Meek, DDS, PC restrict how it uses or discloses my personal health information (PHI) deemed necessary to carry out treatment, payment and healthcare operations (TPO). However, the practice is not required to agree to my requested restrictions. If it does, it is bound by that agreement.

By signing this form, I am consenting to the office of Beau V. Taylor, DDS, PC and Joseph R. Meek, DDS, PC the use and disclosure of PHI and to carry out TPO.

I have the right to revoke my consent in writing. However, if I do not sign this consent, or later revoke it, Beau V Taylor, DDS PC and Joseph R. Meek, DDS, PC may decline to provide treatment for me.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PRINTED NAME OF PATIENT OR LEGAL GUARDIAN

Receipt of Notice of Privacy Practices Written Acknowledgement Form upon request