PATIENT RECORD

Date _____

Gary V. Taylor, D.D.S. P.C.
Joseph R. Meek, D.D.S.
Beau V. Taylor D.D.S.

Patient's Name:
Mr.,Mrs.,Ms._____
(Last) (First) (Middle)
Spouse or legal Guardian_____
(Last) (First) (Middle)

Patient's Date of Birth_____Age_____Sex_____

Social Security #_____

**(Each patient must have "Medical Record" sections filled out completely.)

MEDICAL RECORD

General Health: (please check) EXCELLENT_____ GOOD_____ FAIR_____ POOR_____

Name and Address of
Physician:_____

Phone number of Physician:_____
Last visit to Physician:_____ For what purpose?_____

Are you taking any medication now? Yes____ No____ For what purpose?_____

List any medication(s) you are taking_____
_____
_____

Have you ever had any serious illness or operation: Yes____ No____
If yes, please describe:_____
_____
_____

Have you had, or do you have at present? (please check)

	YES	NO		YES	NO
Heart disease	____	____	Cancer or cancer treatment	____	____
Anemia	____	____	Jaundice	____	____
Heart pacemaker	____	____	Epilepsy	____	____
Angina	____	____	Hepatitis - (circle) A B C	____	____
Asthma or hay fever	____	____	Arthritis	____	____
Congenital heart lesions	____	____	Glaucoma	____	____
Stroke	____	____	Herpes	____	____
Abnormal blood pressure	____	____	AIDS	____	____
Ulcers	____	____	Tuberculosis	____	____
Lung disease	____	____	COPD	____	____
Diabetes	____	____	HIV positive	____	____
Sinus trouble	____	____	Crohn's Disease	____	____

Do you need antibiotics prior to treatment? _____YES _____NO
If yes, for what reason(s)?
____Heart murmur ____Heart valve problems ____Rheumatic fever ____Joint replacement

	YES	NO
Have you been hospitalized within the last 5 years?.	____	____
Have you ever been treated with radiation therapy?.	____	____
Are you allergic to: Penicillin _____Codeine_____ Local injected anesthetics___	____	____
Other medications?:_____		
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?	____	____
Do you chew on only one side of your mouth?.	____	____
Do your gums feel tender or swollen?	____	____
Do you clench or grind your jaws while sleeping or during the day?	____	____
Do you wear dentures?	____	____

If yes, what year were they made?_____

Is there anything concerning your past or present medical or dental history which you feel the doctor should know? If yes, please describe:_____

_____

Reason for visit:_____

When was your last dental visit?_____

Have you ever had any serious problem associated with dental treatment? ____ ____

If yes, explain_____

_____

WOMEN:

Are you, or is there a possibility of pregnancy?. . . . . YES____ NO____ How long?_____

Are you nursing?. . . . . YES____ NO____

****

EMERGENCY INFORMATION

Person to notify in case of emergency (not in same household):_____

(First and Last Name)

Phone Number of that person: home_____

cell:_____

****

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:_____

Address:_____

Phone number:_____

Signature:_____

(Parent's signature if patient is a minor)

FAMILY and FINANCIAL INFORMATION: (This section can be filled out once for all family members.)

Parent/Guarantee's Name_____
(Last) (Middle) (First)

Address incl, Zip Code_____
(Street) (City) (State) (Zip)

Home Phone Number_____ Cell Phone Number_____ Business Phone Number_____

EMAIL Address_____ Place of Employment_____ Occupation_____

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

Spouse's Place of Employment:_____

Spouse's Business Address:_____
(Street) (City) (State) (Zip)

PRIMARY INSURANCE

Parent/Guarantor's Name_____

_____

Social Sec. #_____

Birth Date_____

1st Insurance Co. Name_____

_____

1st Insurance Co. I.D.#_____

SECONDARY INSURANCE

Parent/Guarantor's Name_____

_____

Social Sec. #_____

Birth Date_____

2nd Insurance Co. Name_____

_____

2nd Insurance Co. I.D.#_____

What is your relationship to person(s) listed above? 1st_____ 2nd_____

If you are completing this form for a patient: What is your name?_____

What is your relationship to the patient?_____

How did you learn of our services?_____

Whom may we thank for referring you?_____

****

HEALTH HISTORY UPDATE

(Complete this section at a later date.)

I have reviewed my patient record and it is current.

_____ _____ _____ _____
(Date) (Initials) (Date) (Initials)

_____ _____ _____ _____
(Date) (Initials) (Date) (Initials)

Date_____

Gary V. Taylor, D.D.S.; P.C.
Joseph R. Meek, D.D.S.
Beau V. Taylor D.D.S.

AUTHORIZATION OR CARE/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

If you have dental insurance, we will be happy to assist you in processing your claims for benefits to which you are entitled. 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 who accept such assignment.

I agree to pay all applicable charges, 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 service charge shall be added to the amount due. In the event that I default on the payment of my account, I understand that I am responsible for any and all costs incurred in the collection of my account including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collections, I agree to be responsible for collection fees and interest due on amounts in default.

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.

****Past Due Accounts subject to a 1.75% /month Late Charge**

Date:_____

_____ _____
(Signature) (Relation to Patient, if Minor)

_____ _____
(Witness) (Date)

+++Please list all members (including first and last name) who are covered under your dental plan:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____