## PATIENT INFORMATION

Robert Taylor DENTISTRY

_____
DATE

_____
PATIENT NAME (Last) (First) (Middle)

_____
ADDRESS Number Street City Zip Telephone

_____
PATIENTS DATE OF BIRTH SEX HEIGHT WEIGHT MARITAL STATUS

_____ _____
PERSON RESPONSIBLE FOR PAYMENT SPOUSE NAME OR PARENT IF MINOR

_____ _____
YOUR PLACE OF EMPLOYMENT (OR FATHER'S IF MINOR) SPOUSE PLACE OF EMPLOYMENT (OR MOTHER'S IF MINOR)

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

_____ _____ _____ _____
DENTAL INSURANCE CO. (IF APPLICABLE) GROUP NO. DENTAL INSURANCE CO. (IF APPLICABLE) GROUP NO.

_____ _____
ADDRESS OF SUBSCRIBER BIRTH DATE OF SUBSCRIBER ADDRESS OF SUBSCRIBER BIRTH DATE OF SUBSCRIBER

_____ _____ _____ _____
SOCIAL SECURITY NO. SUBSCRIBER ID NO. SOCIAL SECURITY NO. SUBSCRIBER ID NO.

_____
REFERRED BY:

For those patients who are covered by private insurance, we are pleased to extend the **courtesy** of billing your insurance company for you. In order to provide this service for you, we must have complete insurance information and confirmation of your coverage. We ask that you fill out all forms, which will give us the necessary information. It is our policy that anything not covered by insurance is to be paid for at the time of service. Our office does not guarantee the patient's insurance company will pay. We ask that you read **YOUR** policy to be sure you are fully aware of any limitations of benefits provided. You are responsible for any amount not covered by your insurance.

If you do not have dental insurance, payment is expected at the time of service. We accept MasterCard, Visa, Discover, American Express, and Care Credit.

Signature _____ Date _____

## HIPPA
### Health Insurance Portability and Accountability Act of 1996

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I also understand that my account or treatment will not be discussed with anyone other than myself unless their name is listed below. This includes any spouses or your parents if you are over 18. Even if your parents holds the insurance we may not discuss your account with them unless they are listed below.

I authorize you to speak with: _____

Signature _____ Date _____

# PATIENT HEALTH HISTORY

Patient Name: _____

Patient Date of Birth: _____

Are you currently under the care of a physician? YES NO Last physical exam: _____

Physician Name: _____ Physician Phone: _____

Do you normally pre-medicate (take antibiotics) prior to having dental treatment or dental cleanings? _____

**GENERAL CONDITIONS:**

Y N Present/past tobacco use (smoke or chew)
How much? _____
Y N Present/past alcohol use
How much? _____
Y N Present/past recreational drug use

**EYES:**

Y N Glaucoma
Y N Other/surgery _____

**EARS:**

Y N Pain/discomfort around ears

**RESPIRATORY:**

Y N Tuberculosis
Y N Emphysema
Y N Asthma/hay fever
Y N Other _____

**FEMALE:**

Y N Pregnant; # months _____
Due date _____
Y N Breast-feeding
Y N Birth control pills

**ENDOCRINE:**

Y N Diabetes
Y N Thyroid condition
Y N Hormone imbalance

**NERVOUS SYSTEM:**

Y N Stroke
Y N Epilepsy/seizures
Y N Head or neck injures
Y N Dizziness/fainting

**BONES, MUSCLES:**

Y N Arthritis/Rheumatism
Y N Artificial joints/limbs
Y N Osteoporosis

**DIGESTIVE:**

Y N Hepatitis (Type _____)
Y N Ulcers
Y N Colitis
Y N Gastric Reflux (GERD)
Y N Other _____

**HEART, BLOOD VESSELS:**

Y N Heart problems/trouble
Y N Chest pain/discomfort
Y N Heart murmur

**HEART, BLOOD VESSELS: continued**

Y N Mitral valve prolapse
Y N Congenital heart defect
Y N Pacemaker
Y N Artificial heart valve
Y N High blood pressure
Y N Low blood pressure
Y N Heart surgery
Y N High cholesterol
Y N Other _____

**URINARY:**

Y N Kidney disease
Y N Increased frequency of urination

**BLOOD:**

Y N Anemia or other blood disorders
Y N Do you take a Blood Thinner

**HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:**

Y N Bisphosphonates
Y N Actonel
Y N Boniva
Y N Fosamax
Y N Reclast
Y N Zometa

**OTHER**:

Y N Cancer
Y N Radiation/chemotherapy
Y N HIV/Aids
Y N Psychiatric treatment

**ALLERGIES, REACTIONS:**

Y N Dental asesthesia
Y N Penicillin/other _____
Y N Sulfa drugs
Y N Aspirin/Codeine
Y N Barbiturates/sedatives
Y N Latex
Y N Other _____

**SLEEP MEDICINE:**

Y N Snore or Gasp?
Y N Tired during the day?
Y N Ever had sleep test?
When _____ Where _____
Y N Diagnosed Sleep Apnea
Y N Wear CPAP?
Y N Clench or grind teeth?
Y N Headaches or sore jaw?

**MEDICATIONS**:

Please list names of current medication(s)

_____

The above information is true to the best of my knowledge. Should further information be needed you have my permission to ask the respective healthcare provider, who may release such information to you. I will inform you of any changes in my health or medications.

Signature: _____ Reviewed by: _____ Date: _____