

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone #: _____
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:

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

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 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: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? 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 _____

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone



Name of Patient _____ Date of Birth _____

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
 - _____ 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