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TAYLOR MADE DENTAL
JEREMY J. TAYLOR, DDS

NEW PATIENT INFORMATION *(CONFIDENTIAL)*

Name		M	F	Birthdate		SSN	
Address				City		State	Zip Code
Home Phone			Cell Phone			Preferred #	H / C
Employer				Work Phone			
Minor	Single	Married	Divorced	Widowed	Separated	Spouse/Parent Name	
Whom may we thank for referring you?							
Emergency Contact		Relationship to Patient		Phone Number			

INSURANCE INFORMATION

Name of Policy Holder		Birthdate		SSN	
Name of Employer		Name of Insurance Company			
Insurance Company Address		Member ID		Group #	

SECONDARY INSURANCE *(IF APPLICABLE)*

Name of Policy Holder		Birthdate		SSN	
Name of Employer		Name of Insurance Company			
Insurance Company Address		Member ID		Group #	

I certify that I have read and understand, to the best of my knowledge, the information listed. The medical questions have been accurately answered. I also consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I agree to accept full responsibility for the payment of all fees associated with those procedures or drugs associated with the performance of those procedures. I acknowledge that I am ultimately responsible for the full payment of all such fees and charges. **I acknowledge that payment is due in full at the time of service. I understand there is a 48-hour cancellation policy to avoid missed appointment charges.**

Patient Signature _____ Date _____

Doctor Signature _____

MEDICAL INFORMATION

Name of Physician		Date of Last Visit					
1. Are you currently under medical treatment?				Yes		No	
If yes, please explain							
2. Have you been hospitalized for any surgical operation or illness in the last 10yrs?				Yes		No	
If yes, please explain							
3. Do you use any type of tobacco?				Yes		No	
If yes, what kind and how much?							
4. Do you use any controlled substances?				Yes		No	
If yes, please explain							
5. Do you use any recreational drugs?				Yes		No	
If yes, please explain							
6. Do you drink alcohol?				Yes		No	
If yes, how much per week?							
7. Have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonates?				Yes		No	
If yes, what kind/how much/how long?							
8. Do you or have you been told you snore?				Yes		No	
9. Have you been diagnosed with Sleep Apnea?				Yes		No	
If yes, do you wear a CPAP at night?				Yes		No	
10. Do you get headaches or migraines?				Yes		No	
If yes, how often?							
Questions 11 & 12 Women Only							
11. Are you pregnant or trying to get pregnant?				Yes		No	
If yes, how many weeks?							
12. Are you taking oral contraceptives?				Yes		No	

Are you allergic to or had a reaction to any of the following?

Local Anesthesia (Novocain)	Yes		No		Codeine	Yes		No	
Penicillin	Yes		No		Iodine	Yes		No	
Sulfa Drugs	Yes		No		Latex	Yes		No	
Other Antibiotics	Yes		No		Valium or other Sedatives	Yes		No	
Aspirin	Yes		No		Other				
Other					Other				

Please list any medications, dietary supplements and/or herbal medications you are taking at this time.

MEDICATION/STRENGTH/X DAILY	REASON FORTAKING

Do you have, or have you had, any of the following conditions?

Chest Pains (Angina)	Y		N		Factor 5 (Liden Disease)	Y		N	
Heart Disease (Failure)	Y		N		Bruise Easily	Y		N	
Heart Attack	Y		N		Excessive Bleeding	Y		N	
Heart Surgery	Y		N		Blood Transfusions	Y		N	
Heart Valve Replacement	Y		N		Leukemia	Y		N	
Cardiac Pacemaker	Y		N		Jaundice	Y		N	
Heart Murmur	Y		N		Hepatitis A	Y		N	
Mitral Valve Prolapse	Y		N		Hepatitis B or C	Y		N	
Rheumatic Fever	Y		N		Liver Disease	Y		N	
Rheumatic Heart Disease	Y		N		Eye Problems	Y		N	
High Blood Pressure	Y		N		Glaucoma	Y		N	
Low Blood Pressure	Y		N		Cancer	Y		N	
Stroke	Y		N		Tumors/Growths	Y		N	
Swollen Ankles	Y		N		Radiation Therapy	Y		N	
Sinus Problems	Y		N		Chemotherapy	Y		N	
Asthma	Y		N		Stomach Problems	Y		N	
Shortness of Breath	Y		N		Ulcers	Y		N	
Frequent Coughing	Y		N		Crohn's Disease	Y		N	
Emphysema/COPD	Y		N		Ulcerative Colitis	Y		N	
Easily Winded	Y		N		Thyroid Problems	Y		N	
Respiratory/Lung Problems	Y		N		Recent Weight Loss	Y		N	
Tuberculosis/TB	Y		N		Psychiatric Care	Y		N	
Diabetes	Y		N		Sexually Transmitted Disease	Y		N	
Low Blood Sugar	Y		N		HIV Infection/AIDS	Y		N	
Excessive Thirst	Y		N		Cold Sores/Fever Blister	Y		N	
Frequent Urination	Y		N		Organ Transplants	Y		N	
Kidney Disease/Dialysis	Y		N		TMJ	Y		N	
Epilepsy/Seizures	Y		N		Headaches/Migraines	Y		N	
Joint Replacement	Y		N		Other:				
Arthritis	Y		N		Other:				
Osteoporosis	Y		N		Other:				
Blood Diseases	Y		N		Other:				
Anemia	Y		N		Other:				