



John F. Taylor, DDS Mark A. Broussard, DDS Stuart F. Taylor, DDS
Family Dentistry

W E L C O M E

Thank you for selecting our DENTAL TEAM! We will always offer you the most up to date care available. To help us meet your dental needs, please fill out these forms for us. Yes, we hate forms too, but this information is important. Thank you for your cooperation.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____ Birth Date _____
 Wish to be called _____ Male Female Single Married
 Address _____
 City/State/Zip _____
 Home Phone _____ Work Phone _____ Ext. _____
 Your Employer _____ Your Occupation _____
 Insurance Company Name _____ Date of coverage _____

Name of spouse _____ Date of Birth _____
 Spouse employed by _____ S.S.# _____
 Name of spouse's dental insurance company _____
 Who will be paying for dental services? _____
 Whom may we thank for referring you to our office? _____
 Please circle which Dr. you wish to see Dr. J. Taylor, Dr. Broussard, Dr. S. Taylor.

HOW CAN WE CONTACT YOU?

Cellular Phone _____ Pager _____
 Email _____
 Where do you prefer to receive calls? Home Work Cellular Pager
 When is the best time to reach you? Time _____ Days M T W Th F
 Please list names and phone numbers of three people who will know how to reach you in case of an emergency.

Name: _____ Phone Number _____
 Name: _____ Phone Number _____
 Name: _____ Phone Number _____

DENTAL CONCERNS

WHAT DID YOU NOT LIKE ABOUT YOUR PAST DENTAL APPOINTMENTS?

- WAS THE TREATMENT UNCOMFORTABLE?
- WAS THE STAFF UNFRIENDLY?
- WERE THE FEES NOT EXPLAINED BEFORE YOUR APPOINTMENTS?
- ANYTHING WE HAVE NOT THOUGHT OF? _____

WHAT ARE YOUR FEELINGS ABOUT YOUR:

FRONT TEETH

- ARE YOU HAPPY WITH THEIR COLOR? YES NO
- ARE YOU HAPPY WITH THEIR LENGTH? YES NO
- ARE THEY CROWDED OR CROOKED? YES NO
- ARE YOU HAPPY WITH THEIR OVERALL APPEARANCE? YES NO
- ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

BACK TEETH

- ARE THEY SENSITIVE TO HOT OR COLD FOODS? YES NO
- DO THEY TRAP FOOD WHEN YOU EAT? YES NO
- ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

GUMS

- DO THEY EVER BLEED? YES NO
- ARE THEY SENSITIVE? YES NO
- ARE YOU SEEING A GUM SPECIALIST? YES NO
- IF YES WHO: _____
- DO YOU FEEL YOU HAVE BAD BREATH? YES NO
- ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

MISSING TEETH

- DO YOU HAVE ANY MISSING TEETH? YES NO
- ARE YOU WEARING A REPLACEMENT? YES NO
- IS YOUR DENTURE OR PARTIAL UNCOMFORTABLE? YES NO
- ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

OVERALL On a scale of 1-10, how would you rate the health of your teeth?

1 2 3 4 5 6 7 8 9 10

WHAT IS THE FIRST THING YOU WOULD LIKE FOR US TO HELP YOU WITH?

List in order of importance: _____

WHAT CAN WE DO TO MAKE YOU FEEL MORE AT HOME?

- WOULD YOU LIKE A PERSONAL WALKMAN OR CD PLAYER TO LISTEN TO?
- WILL YOU NEED BLANKETS TO HELP WITH THE TEMPATURE?
- WILL YOU NEED A PILLOW TO SUPPORT YOUR NECK?
- ANYTHING WE HAVE NOT THOUGHT OF? _____

MEDICAL CONCERNS

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. **This information is very important.** Thank you in advance for your cooperation. Indicate which of the following you have had or have at the present.

HEART PROBLEMS

- Heart Disease / Attack YES NO
Heart Failure YES NO
Angina Pectoris YES NO
Congenital Heart Disease YES NO
Heart Murmur YES NO
High Blood Pressure YES NO
Arteriosclerosis YES NO
Mitral Valve Prolapse YES NO
Artificial Heart Valve YES NO
Heart Pacemaker YES NO
Heart Surgery YES NO
Rheumatic Fever YES NO
Stroke YES NO

BLOOD PROBLEMS

- Blood Transfusion YES NO
Hemophilia YES NO
Anemia YES NO
Sickle Cell Disease YES NO
Bruise Easily YES NO

GASTROINTESTINAL

- Ulcers YES NO
Diabetes YES NO
Thyroid Problems YES NO
Liver Disease YES NO
Yellow Jaundice YES NO
Hepatitis A (Infectious) YES NO
Hepatitis B (Serum) YES NO

MUSCLES / BONES

- Arthritis YES NO
Rheumatism YES NO
Jaw Joint Pain YES NO
Cortisone Medication YES NO
Artificial Joints (hips, knee, etc.) YES NO

BREATHING PROBLEMS

- Emphysema YES NO
Chronic Cough YES NO
Tuberculosis YES NO
Asthma YES NO
Hay Fever YES NO
Allergies or Hives YES NO
Sinus Trouble YES NO
Sleep Breathing Disorder YES NO

GENERAL CONCERNS

- Kidney Trouble YES NO
Venereal Disease YES NO
A.I.D.S/H.I.V. Positive YES NO
Epilepsy or Seizures YES NO
Fainting or Dizzy Spells YES NO
Psychiatric Treatment YES NO
Drug Dependence YES NO
Radiation Therapy YES NO
Chemotherapy YES NO
Glaucoma or Recent Eye Surgery YES NO
Ever take Fen-Phen? YES NO
Ever take osteoporosis medication? YES NO
Tobacco Habit YES NO

Physician's Name _____

Are you under a Physician's care at this time YES NO For what condition _____

Please list any medication you are now taking (including over the counter medications.) _____

Have you ever had an allergic reaction to anything? Penicillin Codeine Latex Other _____

FOR WOMEN ONLY:

Are you pregnant? YES, what month? _____ NO Are you nursing? YES NO

Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Dr. Taylor, Dr. Broussard and/or Dr. S. Taylor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Taylor and/or Dr. Broussard to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Taylor, Dr. Broussard and/or Dr. S. Taylor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name) _____ and further authorize and consent that Dr. Taylor, Dr. Broussard and/or Dr. S. Taylor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility of payment for Dental Services provided in this office for myself or my dependents are mine, due and payable at the time of services are rendered unless financial arrangements have been made. **I (we) understand that my (our) credit history is subject to review.** I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____