



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

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Who will be paying for dental services? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

How long since last hygiene appointment? \_\_\_\_\_

Please circle which Dr. you wish to see Dr. J. Taylor, Dr. M. Broussard or Dr. S. Taylor.

## PARENT OR GUARDIAN INFORMATION

Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Birth Date \_\_\_\_\_ Drivers License # \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Date of coverage \_\_\_\_\_

Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Birth Date \_\_\_\_\_ Drivers License # \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance company Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

## HOW CAN WE CONTACT YOU?

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

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 two people who will know how to reach you in case of an emergency.

Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

# 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  YES  NO  
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  YES  NO  
Ever take Fen-Phen?  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 FEMALES 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 and/or Dr. Broussard 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 and/or Dr. Broussard 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 and/or Dr. Broussard 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 1½% 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 \_\_\_\_\_