Old Alabama Family Dentistry
Dr. Gary E. Taylor & Associates, P.C.
www.familydentistryonline.net

3440 Old Alabama Road
Alpharetta, Georgia 30022
770-475-0603/Fax: 770-753-8893

Welcome! Help us get to know you.

Patient Information

Patient Name:_____Date:_____ SSN _____

Street Address: _____ City _____State _____Zip Code _____

☐Male ☐Female Date of Birth_____ ☐Single ☐Married ☐Child Occupation: _____

Home☎:_____ Work☎:_____Cell 📱: _____ E-mail: _____

Preferred Appointment Times: ☐Mornings ☐Afternoons Day of the Week: ☐M ☐T ☐W ☐Th
Preferred Method of Contact: ☐E-mail ☐Cell ☐Home ☐Work

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following conditions? Please check all that apply.

☐ AIDS/HIV+
☐ Allergies_____
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Codeine Allergy
☐ Diabetes
☐ Dizziness/Fainting
☐ Excessive Bleeding
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Latex allergy
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Penicillin Allergy
☐ Radiation/Chemo Treatmt
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures/Epilepsy
☐ Sinus Problems
☐ Steroids/Cortisone
☐ Stomach Problems
☐ Stroke
☐ Tuberulosis
☐ **Pregnancy: Due** _____
_____
☐ **All Rx Medications**: _____
_____ _____
_____
_____
_____
☐ Birth Control Rx
☐ Thyroid Condition
☐ Tumors
☐ Ulcers
☐ Valve – Mitral Prolapse
☐ Venereal Disease

- Have you ever been told that you need pre-medication before any dental procedure? ☐Yes ☐No
- 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: _____
- Are you now under the care of a physician? ☐Yes ☐No Name of Physician_____ Phone: _____
- Do you have any health problems that need further clarification? ☐Yes ☐No If yes, please explain:
  _____
- Do you like your smile? ☐Yes ☐ No Please explain:_____

To the best of my knowledge, all 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:

Please complete PAGE TWO also. Thank you.

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Internet ☐ Yellow Pages ☐ Insurance ☐ Drive-by ☐ Work ☐ Other_____. Name of person referring you to our practice:_____

Spouse, Partner or Responsible Party Information

The following is for the patient's: ☐ Spouse, ☐ Partner, or ☐ Person responsible for payment

Name: _____

Date of Birth_____ Social Security Number:_____ Home: _____

Work ☎: _____Cell: _____ Best time to call: ☐ Mornings ☐Afternoons ☐ Evenings ☐Any time

Street Address: _____City_____ State_____ Zip _____ E-mail_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____

Insurance Information

Name of Primary Policyholder: _____ Is insured a patient? ☐Yes ☐No
Insured's Birth Date: _____ ID#: _____ Group #: _____
Insured's Address: _____
Insured's Employer Name: _____ Address: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office**, financial arrangements** must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care; and financial responsibility for each patient must be determined before treatment.

I also understand that **at least 2 business days notice is required for any appointment changes.** Without this notice, the practice reserves the right to charge a $25 nominal administrative fee for these missed or cancelled appointments (or $25 per half hour or more as specified for appointments with the doctor), as this *time is reserved especially for you*. With notice, your appointment time can be given to a patient who may be waiting.

Emergency dental services, or any services performed without previous financial arrangements, **must be paid for at the time service.**

Patients with dental insurance understand that all dental services provided are charged directly to the patient and that he/she is responsible for payment of his/her estimated portion at the time of service -- and that the patient is ultimately responsible for all services, as payment by an insurance carrier cannot be guaranteed. To facilitate your claims filing, we will help prepare the patient's primary insurance claim or assist you in obtaining payment from insurance companies. All insurance payments will be credited to the patient's account. However, patients are required to pay for all services rendered that are not paid by an insurance company within 60 days.

A **service charge** of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

The **dental fee estimate** provided for any dental care can only be extended for up to three months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of these services to the doctor, or his/her assignee, at the time the services are rendered, or within five (5) days of billing if credit has been extended. I further agree that the reasonable value of these services shall be as paid unless objected to by me, in writing, in the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay the costs and reasonable attorney fees if instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work, as specified above, to discuss matters related to this form. We respect the confidentiality of your medical records and comply with **HIPAA requirements to ensure your privacy**.

I have read the above conditions for treatment/payment and agree to their content. We thank you for choosing **Old Alabama Family Dentistry** for your oral health care. *Welcome to the practice!*

_____ Date: _____ Relationship to Patient: _____
Signature of Patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party