

# Welcome to the Office of John J Taddey, D.D.S.

## MISSION STATEMENT.....

The goal of our office, both doctor and staff, is to provide you, our patients, with the most modern, comprehensive treatment possible. We are an amalgam free (silver filling) office and do only the composite fillings (tooth colored). We try to make all of our patients feel comfortable and welcomed. We hope your visits with us will be as stress free as possible. We try to anticipate your needs and welcome any suggestions and comments on how to improve our services.

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Last First MI Preferred Name  
SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License # \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
E-mail Address (personal) \_\_\_\_\_ E-mail Address (work) \_\_\_\_\_  
Do you need a confirmation regarding appointments?  No  Yes (we confirm and appreciate reschedules 2 business days prior to appointment)  
\*\*\*\* If Yes, preferred way of contacting you regarding appointments:  Home  Cell  Work  Personal E-mail  Work E-mail  
Marital Status:  Minor  Single  Married  Separated  Divorced  Widowed  
If Married, spouse's name \_\_\_\_\_  
If Minor, name of mother and father \_\_\_\_\_  
If Student, Name of School / College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Student Status:  Full Time  Part Time

## RESPONSIBLE PARTY (if other than patient)

Person Responsible for Payment of Account \_\_\_\_\_ Relation to Patient  Self  Spouse  Parent  Other  
SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License # \_\_\_\_\_  
Residence/Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### Primary Dental Insurance Information

Name of Insurance Company \_\_\_\_\_  
Subscriber \_\_\_\_\_ Your Relation to Subscriber  Self  Spouse  Child  Other  
Insured SS # \_\_\_\_\_ Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Provided by Employer?  Yes  No Name of Employer \_\_\_\_\_

### Secondary Dental Insurance Information (if any)

Name of Insurance Company \_\_\_\_\_  
Subscriber \_\_\_\_\_ Your Relation to Subscriber  Self  Spouse  Child  Other  
Insured SS # \_\_\_\_\_ Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Provided by Employer?  Yes  No Name of Employer \_\_\_\_\_

## REFERRAL SOURCE

Name of our patient that referred you? \_\_\_\_\_ How do you know this person? \_\_\_\_\_  
If not referred by our patient, how did you hear about our office? \_\_\_\_\_

## EMERGENCY CONTACT – neighbor or relative not living with you

Name \_\_\_\_\_ Relation \_\_\_\_\_ Best Contact Number \_\_\_\_\_  
Address \_\_\_\_\_

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