

Iajolladentist

John J. Taddey DDS

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. Please return this form upon your appointment.

About Your Child

Child Name: _____

birthdate: _____ **age:** _____ **gender:** M F

Soc. Security No.: ____-____-____ **telephone:** (____)____-____

address: _____

city: _____ **state:** _____ **zip code:** _____

Who will accompany the child? _____

relationship: _____ **do you have legal custody?** Y N

Guardian Information

Mother's Name: _____ stepmother guardian

Soc. Security No.: ____-____-____ **Drivers License** _____

Employer : _____

Home Phone: (____)____-____ **Work Phone:** (____)____-____

Father's Name: _____ stepfather guardian

Soc. Security No.: ____-____-____ **Drivers License** _____

Employer : _____

Home Phone: (____)____-____ **Work Phone:** (____)____-____

Other Guadian Information: _____

yes no Is there anything you would like to discuss with the doctor in private?

Medical & Dental History

physician: _____

phone Number: _____ - _____ last visit: _____

- Good Fair Poor What is the child's current physical health?
 yes no Are the child's immunizations current?
 yes no Is the child taking any medications? if yes, please
list each one: _____

- yes no Does the child have any allergies? if yes, please
describe: _____

Has the child ever had any of the following diseases or medical problems?

- | | | |
|--|--|--|
| <input type="checkbox"/> abnormal bleeding | <input type="checkbox"/> allergies to drugs | <input type="checkbox"/> anemia |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cancer/chemotherapy | <input type="checkbox"/> chicken pox |
| <input type="checkbox"/> congenital heart defect | <input type="checkbox"/> convulsions | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> HIV exposed, but negative | <input type="checkbox"/> handicaps/disabilities |
| <input type="checkbox"/> hearing impaired | <input type="checkbox"/> heart murmur | <input type="checkbox"/> hemophilia |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> hives | <input type="checkbox"/> HIV+/ AIDS |
| <input type="checkbox"/> hospitalized (any reason) | <input type="checkbox"/> kidney/liver problems | <input type="checkbox"/> measles |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> operation (any reason) | <input type="checkbox"/> rheumatic/scarlet fever |
| <input type="checkbox"/> skin rash | <input type="checkbox"/> tuberculosis (TB) | <input type="checkbox"/> other, please describe: |

previous dentist: _____ Last Dental Visit: _____

- Good Fair Poor What is the child's current dental health?
 yes no Has the child ever had a serious or difficult problem
with dental work?
 yes no Is the child's water flouridated?
 yes no Is the child taking flouride supplements?
 yes no Has the child ever had any pain or tender ness in
his/her jaw joint? (TMJ)
 yes no Does the child brush his/her teeth twice daily?
 yes no Was the child breast fed

Does the child have any of the following habits:

- lip sucking/biting nail biting nursing bottle habits thumb/finger sucking

Primary Dental Insurance

Company Name: _____ Phone: (____)____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Group (plan, local, or policy #): _____

Policy Owner: _____ Relation to Patient: _____

Policy Owner's Soc. Security No.: ____-____-_____ birthdate: _____

Policy Owner's employer _____

Employers Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Dental Insurance

Company Name: _____ Phone: (____)____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Group (plan, local, or policy #): _____

Policy Owner: _____ Relation to Patient: _____

Policy Owner's Soc. Security No.: ____-____-_____ birthdate: _____

Policy Owner's employer _____

Employers Address: _____

City: _____ State: _____ Zip Code: _____

Billing Contact

Name: _____ Relationship: _____

Home Phone: (____)____-_____ Work Phone: (____)____-_____

Billing Address: _____

city: _____ state: _____ zip code: _____

Terms of Payment

- I understand that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

- I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. Payment is due in full at the time of treatment unless prior arrangements have been made.

My Method of Payment will be:

cash check credit card

Please sign and date below:

_____ **Date:** _____