McGrady
Dental Group

NEW PATIENT INFORMATION

First Name _____ **Last Name** _____**Middle Initial** _____

Sex: M ☐ F ☐ Birth Date ___/____/____ Marital Status _____

Address _____ City, State, Zip _____

Home phone _____ Cell _____ Work _____

Email _____ Occupation _____

For confirmation calls and any messages regarding treatment and health information (ie. Patients name and diagnosis) we may leave on the following:

☐ Home Phone ☐ Cell ☐ Work Phone ☐ Email

Previous Dentist _____ Date of last visit _____ Date of last dental X-rays? _____

Names of other family members seen in our office _____

_____

Who may we thank for your referral? _____

Reason for today's visit _____

MEDICAL INFORMATION

Physician's Name _____Office Name _____ Phone number _____

Are you currently taking any medications? _____

_____

Have you ever been hospitalized for any surgery or illness in the past 5 years? _____

Do you have any history of or difficulty with (please circle all that apply)

Anemia/Bleeding	Emphysema	Hepatitis
Arthritis	Fever Blisters	High/Low Blood Pressure
Asthma/Breathing Problems	Glaucoma	HIV+/AIDS
Cancer/Tumors	General Anesthesia/Surgery	Immune Deficiency
Cerebral Palsy	Hay Fever	Kidney/Liver Disease
Diabetes	Hearing	Seizures/Epilepsy/Convulsions
Drug Abuse	Heart Problems/Defect	Thyroid Problems

If other, please explain _____

Comments/Details _____

Do you use or have used any form of tobacco? _____ If yes, how often and how much? _____

Do you have allergies or allergic to any medications (Please list) _____

_____

_____

WOMEN ONLY: Are you taking birth control? _____ Are you pregnant? _____ Number of weeks? _____

Dr. Jodi McGrady and Dr. Michael Spilotro
(858) 748-3090 McGradyDental@gmail.com
12350 Oak Knoll Rd. Poway, CA 92064

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DENTAL INFORMATION

Do you brush your teeth regularly _____ How often do you floss? _____ Do you use mouthwash? _____

Are you currently in any discomfort? _____

Do your gums ever bleed? _____ Ever itch? _____ Have you had periodontal disease? _____

Are your teeth sensitive to hot, cold, or anything else? _____ If so when? _____

Do you ever have jaw or TMJ pain? _____

Have you been seen or treated for orthodontics? _____ If so, name of Orthodontist? _____

How may we help to make this visit a positive experience for you? _____

_____

EMERGENCY CONTACT

First Name _____ Last Name _____ Middle Initial _____

Home Phone _____Cell Phone _____ Relationship to you _____

FINANCIAL POLICY, AUTHORIZATION and HIPAA

Your estimated share of cost is due and payable on the day the treatment is performed, unless prior approved financial arrangements have been made. All accounts must be paid within 30 days of the first statement. Any charges not paid within 45 days of receipt of statement are subject to a finance charge of 1.5% per month (18% annual rate).

Patients are responsible for all dental treatment not covered by the insurance company. Any disputes of coverage need to be handled through the insurance company directed by you.

To avoid missed appointment charges we request that cancellations are made 48 hours prior to the appointment. In doing so this appointment may then be made available to another family. A charge will automatically be placed after two consecutive broken appointments. A broken appointment is considered a "no show" or canceling an appointment less than 48 hours prior.

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

I HAVE READ AND UNDERSTAND HIPAA. I AM SIGNING IT VOLUNTARILY AND AUTHORIZE THE DISCLOSURE OF MY AND MY CHILD/CHILDREN'S HEALTH INFORMATION AS DESCRIBED IN HIPAA.

Print name _____Date ____/_____/_____

Signature _____

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