McGrady Dental Group

NEW PATIENT INFORMATION

Child's Name _____ **Nickname** _____

Sex: M ☐ F ☐ Birth Date ___/___/___ Age ____ Reason for visit? _____

Is this your child's first dental visit? _____ Date of last visit ___/___/___ Previous Dentist _____

Your Child's attitude toward previous dental care? _____

Names of other siblings seen in our office _____

_____

Who may we thank for your referral? _____

MEDICAL INFORMATION

Pediatrician's Name _____Office Name _____ Phone number _____

Is your child taking any medications? _____ What kind? _____

Reason for medications _____

Has your child been hospitalized? _____ If so when and why? _____

Has your child had a history or difficulty with (please circle all that apply)

Anemia/Bleeding	Cleft Lip/Palate	Hepatitis
Arthritis	Developmental	Immune Deficiency
Asthma/Breathing Problems	Diabetes	Kidney/Liver
Autism	Eyes, Ears, Nose, Throat	Liver
Bones	General Anesthesia/Surgery	Seizures/Epilepsy/Convulsions
Cancer/Tumors	Hearing	Syndromes
Cerebral Palsy	Heart	Other

Comments/Details _____

Allergies to Medications or food _____

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ Or breast fed? _____ Until what age? _____

Does your child have any mouth habits such as: Finger/thumb sucking, pacifier or other? _____

Has your child ever had any trauma to their mouth or head? _____ When? _____ Details _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____ Does your child floss? _____

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

Describe your child: Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐

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

_____

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

McGrady
Dental Group

Parent 1

First Name _____ Last Name _____ Middle Initial _____

Address _____ City, State, Zip _____

Home phone _____ Cell _____ Work _____

Email _____ Relationship to child _____

Parent 2

First Name _____ Last Name _____ Middle Initial _____

Address _____ City, State, Zip _____

Home phone _____ Cell _____ Work _____

Email _____ Relationship to child _____

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

FINANCIAL POLICY, AUTHORIZATION and HIPAA

Your child's 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).

Parents 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 my child 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.

Signature _____ Print name _____

Relationship to child _____ Date _____

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