Thomas E. Jacka, D.D.S.
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Federal Way, WA 98003
253-946-3575

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME_____ Date of Birth_____ Soc. Sec. #_____

Child's Nickname_____ Sex_____ School_____

Child's Address_____ State_____ Zip_____

Father's Complete Name_____ Father's Birthdate_____
(or male guardian)

Home Address (if different from child's)_____ Home Phone_____

Soc. Sec. #_____ Cell Phone_____

Employed By_____ City_____ State_____ Zip_____

Present Position_____ How long held?_____ Work Phone_____

MOTHER'S Complete Name_____ Mother's Birthdate_____
(or female guardian)

Home Address (if different from child's)_____ Home Phone_____

Soc. Sec. #_____ Cell Phone_____

Employed By_____ City_____ State_____ Zip_____

Present Position_____ How long held?_____ Work Phone_____

Who is responsible for payment?_____ Phone number to call about appointments_____

Name of person who referred you_____

INSURANCE AND FINANCIAL INFORMATION

PRIMARY

INS. CO._____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____

UNION/GROUP #_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S ADDRESS_____

PHONE #_____ CELL #_____

SUBSCRIBERS SS#_____

DATE OF BIRTH_____

EMPLOYER_____

EMPLOYER PHONE #_____

PATIENT RELATIONSHIP TO SUBSCRIBER:

❑ SELF ❑ SPOUSE ❑ DEPENDENT

SECONDARY

INS. CO._____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____

UNION/GROUP #_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S ADDRESS_____

PHONE #_____ CELL #_____

SUBSCRIBERS SS#_____

DATE OF BIRTH_____

EMPLOYER_____

EMPLOYER PHONE #_____

PATIENT RELATIONSHIP TO SUBSCRIBER:

❑ SELF ❑ SPOUSE ❑ DEPENDENT

***All blanks must be completed above, before we can bill insurance directly.**

PLEASE TURN PAGE OVER

DENTAL HISTORY

Is this your child's first visit to the dentist? ❑ Yes ❑ No

Has your child been having any specific problems? ❑ Yes ❑ No Describe_____

_____

Last dental visit_____ Purpose_____ Last complete exam_____

MEDICAL HISTORY (Confidential. Repeated every five years.) Child's Birthdate (Month/Day/Year)_____

Pediatrician/Doctor's Name_____ Last physical exam_____ Current age_____

Does your child have any medical problems? ❑ Yes ❑ No Describe_____

Does your child have special needs we should be aware of? ❑ Yes ❑ No Describe_____

Is your child under a doctors care now? ❑ Yes ❑ No If so, for what reason?_____

Is your child taking any medications, pills or drugs? ❑ Yes ❑ No Please list_____

Has your child ever had any of the following? Indicate YES with check mark (✓).

❑ Heart disease	❑ Measles	❑ Tonsillitis	❑ Hepatitis	❑ Fainting spells	❑ Allergy to medicine/drugs
❑ Heart murmur	❑ Mumps	❑ Jaundice	❑ Prolonged bleeding	❑ Seizures or convulsions	❑ Allergy to anesthetics
❑ Rheumatic fever	❑ Scarlet fever	❑ Kidney disease or dialysis	❑ Herpes	❑ Psychiatric treatment	❑ Allergy to foods
❑ High blood pressure	❑ Typhoid fever	❑ Tuberculosis	❑ Malignancies	❑ Prosthetic valves/joints	❑ Other allergies
❑ Diabetes	❑ Chicken pox	❑ Arthritis	❑ Epilepsy	❑ Asthma	

List all of your child's allergies here_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetic, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Date _____ Witness _____

Parent / Responsible Party's Signature_____

Relationship to Patient _____