



Dentistry for Infants, Children, and Young Adults

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PATIENT INTRODUCTION

This confidential information is of great value in aiding us to better understand and treat your child.

Whom may we thank for referring you to our office? _____

Child's name _____ Nickname _____ Sex M F
(First) (MI) (Last)

Age _____ Birthdate ____ / ____ / ____ Today's Date _____

Name & age of brothers/sisters _____

Child's address _____ City _____ Zip _____

Residence phone () _____

Nearest relative not living with child _____

Address _____ Phone () _____

Father's Name _____ Occupation _____

Father's Address _____ City _____ Zip _____

Father's Employer _____ Work Phone # _____

Father's Date of Birth _____

Father's Social Security # _____ Driver's License # _____

Father's Dental Insurance Co. _____ Group # _____

Mother's Name _____ Occupation _____

Mother's Address _____ City _____ Zip _____

Mother's Employer _____ Work Phone # _____

Mother's Date of Birth _____

Mother's Social Security # _____ Driver's License # _____

Mother's Dental Insurance Co. _____ Group # _____

FAMILY HISTORY

1. Pediatrician _____ City _____

2. Date and results of last physical examination _____

3. Family Dentist _____ City _____

4. Has mother or father experienced a great amount of tooth decay? YES NO

5. What is the child's favorite sport? _____ toy? _____

PLEASE COMPLETE REVERSE SIDE



MEDICAL HISTORY

- 1. Is your child presently under the care of a physician other than for routine care? YES NO
If so, for what reason? _____
- 2. Has your child EVER been prescribed ANY medications? (including antibiotics) YES NO
Medicine _____ Dosage _____
- 3. Has there been any change in his/her health within the past year? YES NO
- 4. Is your child sensitive or allergic to any drugs (e.g. penicillin?) YES NO
- 5. Is your child sensitive or allergic to Latex? YES NO
- 6. Does your child have a history of allergies? YES NO
- 7. Is your child subject to blood disorders? YES NO
- 8. Does your child bruise easily? YES NO
- 9. Has your child had a history of heart trouble, rheumatic fever, diabetes, asthma, epilepsy, tuberculosis, brain injury, kidney, liver, lung or other physical disorders that the doctor should be aware of? *(Please circle those that apply.)*
- 10. Does your child have Acquired Immune Deficiency Syndrome (AIDS)? YES NO
- 11. Has your child ever been hospitalized or had surgery? YES NO
Reason? _____ Date ____ / ____ / ____
- 12. Does your child have a learning disability? YES NO _____

DENTAL HISTORY

- 1. Is this your child's first dental visit? YES NO
- 2. Has your child had an unfavorable experience at another office? YES NO
- 3. How do you think he/she will act toward the dentist? _____
- 4. Has your child been seen by an orthodontist? YES NO
- 5. How many times per day does your child brush his/her teeth? _____
- 6. Is dental floss used? YES NO
- 7. Is fluoride taken in any form? (water, tablets, etc.) YES NO
- 8. Does your child have a history of finger sucking _____ lip sucking _____ nail biting _____ pacifier _____ ?

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian Date

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company
and assign directly to Young Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Young Smiles to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian Date