**Dentistry for Infants, Children, Young Adults,
and Children with Special Needs**

Specialists in Pediatric Dentistry
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YoungSmilesCA.com

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

Age __________ Birthdate MM/DD/YYYY___/___/________ Today's Date MM/DD/YYYY___/___/________

Names & ages of brothers/sisters ______________________________

Child's Address ______________________________ City ______________ Zip ______________

Residence phone (_____) __________-_____________ Email ______________________________

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 MM/DD/YYYY___/___/________ Cell Phone # (_____) ________ - ________

Father's Social Security # ________-________-_________ Driver's License # ____________________

Father's Dental Insurance Co. ______________________________ Group # ____________________

ID# ______________________________

Mother's Name ______________________________ Occupation ______________________________

Mother's Address ______________________________ City ______________ Zip ______________

Mother's Employer ______________________________ Work Phone # (____) _______ - ________

Mother's Date of Birth MM/DD/YYYY___/___/________ Cell Phone # (_____) ________ - ________

Mother's Social Security # ________-________-_________ Driver's License # ____________________

Mother's Dental Insurance Co. ______________________________ Group # ____________________

ID# ______________________________

FAMILY HISTORY

1. Pediatrician ______________________________ City ______________________________
2. Date and results of last physical examination ______________________________
3. Parent Dentist ______________________________ City ______________________________
4. Has mother or father experienced a great amount of tooth decay? ☐ Yes ☐ No ☐ Mom ☐ Dad

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 these physical disorders that the doctor should be aware of? ☐Yes ☐No
   ☐ Heart trouble ☐ Rheumatic fever ☐ Diabetes ☐ Asthma ☐ Epilepsy ☐ Tuberculosis
   ☐ Brain Injury ☐ Kidney ☐ Liver ☐ Lung ☐ Other
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 ____________________ MM/DD/YYYY___/___/________
12. Does your child have a learning disability?____________________ ☐ Yes ☐ No

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DENTAL HISTORY

1. Is this your child's first dental visit? ☐ Yes ☐ No If no, date of last visit: MM/DD/YYYY___/___/________
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 If yes, name ____________________
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 these situations that the doctor should be aware of? ☐ Yes ☐ No
   ☐ finger sucking ☐ lip sucking ☐ nail biting ☐ pacifier ☐ teeth grinding

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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.

____________________ ____________________ MM/DD/YYYY___/___/________
Signature of Parent/Guardian Printed Name

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 benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____________________ ____________________ MM/DD/YYYY___/___/________
Signature of Parent/Guardian Printed Name