Welcome To Our Office

CHILD PATIENT INFORMATION

Date _____

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ City _____ Zip _____

Home Phone: _____ Birthdate: _____ Age _____ School _____ Grade _____

Parent's cell phone _____ Best Phone Number to Call _____
(If you don't have special preference, we'll call your cell phone as priority)

e-mail address _____

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

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient resides with: ☐ Mother ☐ Father ☐ Both ☐ Other

	FATHER	MOTHER
Name:		
Address (If different from above):		
Phone (If different from above):		
Social Security Number:		
Employer's Name:		
Business Address:		
Business Phone:		

Person Responsible for Account _____

IF other than parent:

Name _____ Address: _____ Phone: _____

INSURANCE INFORMATION

	PRIMARY	SECONDARY
Name of insured (Employee)		
Date of Birth (mo/day/year)		
Insurance Company		
Group Number		
Social Security number		

Assignment and Release

I, the undersigned certify that I have insurance coverage. I understand that I am financially responsible for all charges whether or not paid insurance. I hereby authorize Dr. Lee or Dr. Yeh to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

X _____ _____

Signature of responsible party Relationship Date

This information is completely confidential.

Patient Name _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ **Phone** # _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check if you have had problems with any of the following

- □ Bad Breath
- □ Bleeding gums
- □ Clicking or popping jaw
- □ Grinding teeth
- □ Sensitivity to hot
- □ Loose teeth or broken fillings
- □ Periodontal treat treatment
- □ Sensitivity to cold
- □ Food collection between teeth
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physicians Name _____ Date of last visit _____

Have you had any serious illnesses or operations? □Yes □No If yes, describe _____

Have you ever had a blood transfusion? □Yes □No If yes, give approximate dates _____

(Female) Are you pregnant? □Yes □No Nursing? □Yes □No Taking Birth control pills? □Yes □No

Have you ever taken diet pills? □Yes □No If yes, please list _____

Check if you have or had any of the following

- □ AIDS
- □ Anemia
- □ Skin Rash
- □ Stroke
- □ Artificial Joints
- □ Asthma
- □ Back Problem
- □ Blood Disease
- □ Cancer
- □ Ulcer
- □ Chemotherapy
- □ Venereal Disease
- □ Bulimia
- □ Cortisone Treatment
- □ Cough, Presistent
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Osteoporosis
- □ Heart Murmur
- □ Heart Problems? Describe _____
- □ Hemophilia
- □ Ulcer or Gastroesophageal reflux disorder
- □ Hepatitis
- □ Rheumatic Fever
- □ HIV Positive
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Thyroid Problem
- □ Nervous Problems
- □ Pacemaker
- □ Psychiatric Care
- □ Tonsillitis
- □ Tuberculosis
- □ High Blood Pressure
- □ Mitral Valve Prolapse
- □ Shortness of Breath
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Swelling Of Feet or Ankles
- □ Scarlet Fever
- □ Tobacco Habit
- □ Radiation Treatment
- □ Respiratory Disease
- □ Chemical Dependency
- □ Circulation Problems
- □ Acid Regurgitation

MEDICATIONS

List medications you are currently taking

_____

_____

Pharmacy Name _____

Phone #: _____

ALLERGIES

- □ Aspirin
- □ Penicillin
- □ Sulfa
- □ Barbiturates
- □ Codeine
- □ (Sleeping pills)
- □ Local Anesthetics
- □ Other _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Today's Date _____ **Guardian's Signature** _____