LISA YOUNG DDS
FAMILY DENTIST

Patient Information

Date________

Child's Name____
Last First (Preferred) MI

Sex ☐ Male ☐ Female

Birthdate _________________________ Age ___________

Address____

City _____________________ State______ Zip________

School ___________________________ Grade __________

Parent

☐ Step-parent ☐ Guardian

Name____

Home Phone (___) ________ Cell phone (___)________

Work Phone (___) ________ E-mail _________________

Employer ____

Occupation ____

Parent

☐ Step-parent ☐ Guardian

Name____

Home Phone (___) ________ Cell phone (___)________

Work Phone (___) ________ E-mail _________________

Employer ____

Occupation ____

Primary Insurance

Insurance Subscriber ____ Birthdate______________
Last Name First Name

Relation to Patient________________________________

Address (if different from patient's)____ Phone (_____) ______________

City ____ State________ Zip_______________________

Employer ____

Insurance Company ____

ID # ____________________________ Group # __________________ Insurance Company Phone _____________________

Authorization & Release

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I authorize the Dentists and staff to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Parent/Guardian Signature ____ Date____________

Dental and Health History

Your child's overall health as well as any medications which your child may take could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? ____________________

Do you (parent) help with brushing/flossing? ☐ Yes ☐ No

Is your child's water fluoridated? ____________________

How often does your child drink soda or juice? __________

How often does your child floss? __________________

Does your child take fluoride supplements? ☐ Yes ☐ No

How often does your child snack between meals on sweets, starches or gum? _________________________________

Does your child:

Suck thumb/finger?	☐ Yes ☐ No	Bite/chew nails?	☐ Yes ☐ No	Grind teeth?	☐ Yes ☐ No
Suck/bite lip?	☐ Yes ☐ No	Chew hard objects?	☐ Yes ☐ No	Clench jaws?	☐ Yes ☐ No
Snore?	☐ Yes ☐ No	Bed wetting?	☐ Yes ☐ No		

Previous dentist _______________________ City, State ____________________ Date of last dental visit ____________

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's Physician ____ Phone number _________________________

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

____ ______________________

____ ______________________

____ ______________________

Is your child currently taking medications? ☐ Yes ☐ No (If yes, please list)________________________________

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc)? ☐ Yes ☐ No (If yes, please describe) ____

Does your child have a history of allergies to any other substances (latex, environmental, etc)? _____________________

Has your child ever had any of the following:

Abnormal bleeding	☐ Yes ☐ No
ADD/ADHD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Autism	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Congenital heart defect	☐ Yes ☐ No
Convulsions/Epilepsy	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Handicaps/Disabilities	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
Hemophilia/Bleeding Disorder	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No
Learning Disability	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Stomach, liver or kidney problems	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No

A persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks) ☐ Yes ☐ No

Please explain any medical problems your child has: ____

____

Patient Name (Print) ____

Parent/Guardian Signature ____ Date_______________

Doctor's Signature ____