YOUNG SMILES PEDIATRIC DENTISTRY & SPA, P.A.

"Kids Love Us, Parents Enjoy Us"

KERA YOUNG, D.D.S.

GENERAL INFORMATION

Patient Name:_____Nickname_____Sex: ( )M ( )F

Birth Date:_____ Present Weight: _____ Age: _____

Mother's Name: _____ Father's Name: _____

Mother's D.O.B. _____ Father's D.O.B.:_____

Home Address: _____

City: _____ State: _____ Zip:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Mother's Employer: _____ Work Phone: ( ) _____

Father's Employer: _____ Work Phone: ( ) _____

Preferred method of contact: ( ) Email _____ ( ) Home ( ) Cell ( ) Work

How did you hear about us or who referred you? _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Date and reason for last visit: _____

Were there any problems at birth? ( ) Yes ( ) No If yes, explain: _____

Is your child in good general health? ( ) Yes ( ) No

Are your child's immunizations up to date? ( ) Yes ( ) No

Is your child taking medication now? ( ) Yes ( ) No

If yes, list medications being taken: _____

_____

Has your child had or does your child now have (please circle Yes or No as indicated for each number):

1. Allergies……Yes No
2. Heart Trouble or heart murmur…….....Yes No
3. Rheumatic heart disease or fever……..……Yes No
4. Reaction to any medication……...Yes No
5. Blood diseases or anemia……..Yes No
6. Venereal disease……Yes No
7. AIDS virus……....Yes No
8. Herpes virus……..Yes No
9. Diabetes……Yes No
10. Ear, eye, nose, or throat problems……...Yes No
11. Cancer, tumors, growths, or cysts……...Yes No
12. Any steroid therapy or chemotherapy……Yes No
13. Neurological /mental disorders……...Yes No
14. Convulsions or seizures……...Yes No
15. Frequent diarrhea or vomiting……Yes No
16. Mumps, measles, or chickenpox……..Yes No
17. Eating disorders……...Yes No
18. Asthma……Yes No
19. Operations/Hospitalization……Yes No
20. Facial injuries or tooth pain……Yes No
21. Abnormal bleeding or bruising……...Yes No
22. Anemia……Yes No
23. Blood transfusions……..Yes No
24. Birth defects……Yes No
25. Cleft lip or palate……Yes No
26. Scarlet fever ……...……Yes No
27. Febrile Fever……..……Yes No
28. Liver trouble……Yes No
29. Jaundice or hepatitis……Yes No
30. Frequent infections……..Yes No
31.High or low blood pressure……...Yes No

Females only:

32. Could your child be pregnant?.....Yes No

Please list question number and give explanation for any "Yes" answer: _____

_____

_____

DENTAL HISTORY

Patient Name: _____Why is your child here today? _____

Do you have any concerns today? _____ If yes, what? _____

Has your child been to the dentist before? _____ If yes, when? _____

Has your child had dental x-rays before? _____ If yes, when? _____

Child's personality: ( ) Friendly ( ) Happy ( ) Shy ( ) Nervous ( ) Anxious ( ) Afraid ( ) Resistant

Does or did your child have any oral habits like thumb sucking, tongue thrust, etc.? _____If yes, what type?_____

Does your child receive fluoride in any form? _____ If yes, what type? _____

Is your child taking the pacifier, bottle, cup with top (sippy cup)? _____ If yes, which type? _____

Has your child ever worn retainers, space maintainers, or other oral appliances? _____ If yes, what type? _____

Has your child had nitrous oxide (laughing gas)? _____ If yes, was the response good? _____

Has your child had jaw problems, pain, clicking or popping of the jaw? _____ If yes, specify: _____

ACCOUNT INFORMATION

Self Pay ( ) Name of person responsible for payment: _____ [If checked, skip to disclaimer.]

Information on file ( ) [Check here only if current insurance information has already been provided and verified. If checked, skip to disclaimer.]

Dental Insurance Carrier: _____

Address of Carrier (see back of card): _____

Phone: ( ) _____

Name of Insured: _____ SS#, DOB, or ID#: _____

Insured's Employer: _____ Group #: _____

Disclaimer:
Insurance benefits are ESTIMATED and processed as a courtesy. Your actual insurance benefits may be less. You, the parent or legal guardian, are responsible for all amounts not covered by your insurance carrier and all financial obligations for dental services provided. If for some reason the account becomes delinquent, you agree to pay for all rebilling charges, interest charged, collection costs and attorney fees.

Signature of Parent / Legal Guardian: _____ Date: _____

CONSENT FOR DENTAL TREATMENT

Please read this form carefully and ask about anything you do not fully understand.

With regard to my child _____, I _____
Print Patient Name Print Parent/Legal Guardian Name

Voluntarily request Dr. Kera Young to perform dental treatment on my child, including but not limited to x-rays and the administration of local anesthesia, deemed necessary or advisable to the planned treatment. I further understand and consent to the use of behavior management techniques to facilitate the rendering of necessary dental treatment, including but not limited to nitrous oxide (laughing gas). I further consent to the taking of photographs and x-rays before, during and after treatment for the use of scientific papers, research, and demonstration. **If I wish any exceptions, I have so noted as follows_____ If you wish no exceptions, please write "NONE" here: _____**

_____	_____	_____
Signature Parent or Legal Guardian	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**