YAGASAKI DENTAL CENTER

Welcome and thank you for choosing Yagasaki Dental Center! We provide advance family and cosmetic dentistry for every major dental need. We strive to make each of you child's visit and pleasant comfortable. Our goal is to teach you rchild oral habits which will help keep their smile beautiful for the rest of their lifetime. ☺

DATE:_____

I. Child's Information

NAME:_____ NICKNAME:_____

BIRTHDATE:_____ AGE:_____

SOC. SEC. #:_____ SEX:_____

SCHOOL:_____ GRADE:_____

HOME ADDRESS:_____

STREET CITY STATE ZIP CODE

II. Responsible Party

NAME:_____ RELATIONSHIP:_____

SOC. SEC. #:_____ DRIVER'S LICENSE #:_____

ADDRESS:_____

STREET CITY STATE ZIP CODE

E-MAIL:_____ HOME PHONE:_____ WORK PHONE:_____

WHEN IS THE BEST TIME TO REACH YOU? TIME:_____ DAYS:_____

❒ **MOTHER** ❒ **Stepmother** ❒ **Guardian**

NAME:_____

HOME PHONE:_____ WORK PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

SOC. SEC. #:_____ DRIVER'S LICENSE #:_____

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ DIVORCED

❒ WIDOWED ❒ SEPARATED

❒ **FATHER** ❒ **Stepfather** ❒ **Guardian**

NAME:_____

HOME PHONE:_____ WORK PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

SOC. SEC. #:_____ DRIVER'S LICENSE #:_____

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ DIVORCED

❒ WIDOWED ❒ SEPARATED

III. IN CASE OF EMERGENCY

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?_____

HOME PHONE:_____ PAGER:_____

RELATIONSHIP TO PATIENT:_____

IV. DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURED:_____ SOC. SEC.#:_____

RELATIONSHIP TO PATIENT:_____ BIRTHDAY:_____

EMPLOYER:_____ DATE EMPLOYED:_____ OCCUPATION:_____

INSURANCE COMPANY:_____ GROUP #:_____

INS. CO. ADDRESS:_____

STREET CITY STATE ZIP CODE

EMPLOYEE ID. #:_____ DEDUCTIBLE:_____

AMOUNT ALREADY USED:_____ MAX. ANNUAL BENEFIT:_____

ORTHODONTIC COVERAGE? ❒ **YES** ❒ **NO**

ADDITIONAL INSURANCE

NAME OF INSURED:_____ SOC. SEC.#:_____

RELATIONSHIP TO PATIENT:_____ BIRTHDAY:_____

EMPLOYER:_____ DATE EMPLOYED:_____ OCCUPATION:_____

INSURANCE COMPANY:_____ GROUP #:_____

INS. CO. ADDRESS:_____

STREET CITY STATE ZIP CODE

EMPLOYEE ID. #:_____ DEDUCTIBLE:_____

AMOUNT ALREADY USED:_____ MAX. ANNUAL BENEFIT:_____

ORTHODONTIC COVERAGE? ❒ **YES** ❒ **NO**

V. FINANCIAL AGREEMENT

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.
PLEASE CHECK THE OPTION WHICH YOU PREFER.

_____ **CASH** _____ **PERSONAL CHECK**

_____ **CREDIT CARD** ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ CARE CREDIT ☐ AMERICAN EXPRESS

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In case of default on payment of this account, I agree to pay collection cost and reasonable attorney fees uncurred in attempting to collect on this amount or any future outstanding account balances.

V. FINANCIAL AGREEMENT

I authorized the dentist to release any information including the diagnosis and the recods of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.
authorized and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to m
I understand that my dental insurance carrier may pay less that the actual bill for services. payment of
I agree to be responsible for services rendered on my behalf or my dependents

X_____

SIGNATURE OF PARENT OR RESPONSIBLE PARTY DATE

YAGASAKI
DENTAL CENTER

CHILD'S HEALTH HISTORY

Your child's overall health as well as any medications he/she takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely. Thank you!

CHILD'S NAME:_____ BIRTHDATE:_____ TODAY'S DATE:_____

DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH HIS/HER TEETH?_____
HOW OFTEN DOES YOUR CHILD FLOSS?_____
DATE OF LAST DENTAL VISIT?_____ PREVIOUS DENTIST:_____
PREVIOUS DENTIST'S ADDRESS:_____ PHONE:_____

DOES YOUR CHILD…:	YES	NO
Suck thumb/finger?	❒	❒
Suck/bite lips?	❒	❒
Bite/chew nails?	❒	❒
Chew hard objects (pencils, etc.)?	❒	❒
Grind teeth?	❒	❒
Clench jaw?	❒	❒

	YES	NO
Is your child's water fluoridated?	❒	❒
Does your child take flouride supplements?	❒	❒

MEDICAL HISTORY

HAS YOUR CHILD HAD DIFFICULTY WITH PREVIOUS DENTAL VISITS?:_____
IF YES, PLEASE EXPLAIN:_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

	YES	NO
ASTHMA	❒	❒
CANCER	❒	❒
HEPATITIS	❒	❒
HIV/AIDS	❒	❒
HEMOPHILIA	❒	❒
ABNORMAL BLEEDING	❒	❒
ALLERGIES	❒	❒
LOW BLOOD COUNT	❒	❒

	YES	NO
HANDICAPS/DISABILITIES	❒	❒
TUBERCULOSIS	❒	❒
DIABETES	❒	❒
RHEUMATIC FEVER	❒	❒
CONGENITAL HEART DEFECT	❒	❒
HEART MURMUR	❒	❒
CONSULSION/EPILEPSY	❒	❒

OTHER NOT LISTED:_____

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 I my child's medical status.
I also authorize the dental staff to perform the necessary dental services my child may need.

X_____

SIGNATURE OF PARENT/GUARDIAN DATE

FOR DENTIST ONLY

****DENTIST'S REVIEW****

DENTIST:_____ DATE:_____

HEALTH HISTORY UPDATE

DATE	COMMENTS	PATIENT	DENTIST	HYGIENIST