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

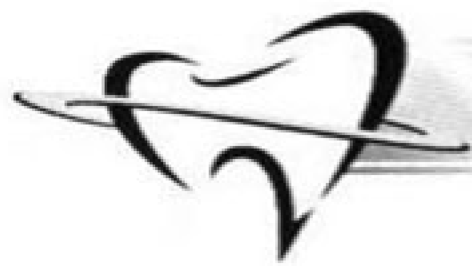
If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental 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



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