Welcome to the Dental Office of Dr. David S. Yasuda!

We strive to make your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits that will help keep their smile beautiful for a lifetime.
To help us meet your family's dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Today's Date _____

Your Child

Child's Name _____
Nickname _____ Sex ☐ Male ☐ Female
Email _____
Birthdate _____
SS # _____
School _____ Grade _____
Child's home address _____
City / State / Zip _____
Phone _____

☐ Mother ☐ Stepmother ☐ Guardian
Name _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS # _____
Employer _____
Occupation _____

☐ Father ☐ Stepfather ☐ Guardian
Name _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS # _____
Employer _____
Occupation _____

Parent's Marital Status

☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Separated
Child lives with: _____

Who is responsible for making appointments?

Name _____
Home Phone _____
Work Phone _____
Cell Phone _____
Best time to call _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
SS # _____
Birthdate _____
Employer _____ Date Employed _____
Insurance Company _____
Group No _____
Ins. Co. Address _____
City / State / Zip _____
Deductible $ _____ Max Ann Benefit $ _____

Additional Insurance

Insured's Name _____
Relationship _____
SS # _____
Birthdate _____
Employer _____ Date Employed _____
Insurance Company _____
Group No _____
Ins. Co. Address _____
City / State / Zip _____
Deductible $ _____ Max Ann Benefit $ _____

Financial Arrangements

Payment in full is required at each appointment.

Primary Care Physician _____
Phone ( ) _____
Pharmacy _____
Phone ( ) _____

Whom may we thank for referring you?

Name _____

~ Next page please ~

Health History

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

Has your child had a history or difficulty with any of the following conditions?

Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition
☐	☐	Abnormal Bleeding	☐	☐	C. O. P. D.	☐	☐	HPV	☐	☐	Radiation Therapy
☐	☐	Acid Reflux / Ulcers	☐	☐	Colitis	☐	☐	Heart Attack	☐	☐	Rheumatic Fever
☐	☐	Alcohol Abuse	☐	☐	Congenital Heart Defect	☐	☐	Heart Surgery	☐	☐	Seizures
☐	☐	Allergies/Hay Fever	☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Drug Abuse History	☐	☐	Hepatitis A B C	☐	☐	Sickle Cell or Trait
☐	☐	Angina Pectoris	☐	☐	Epilepsy	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Fainting Spells	☐	☐	High Cholesterol	☐	☐	Sleep Apnea/Snoring
☐	☐	Artificial Heart Valve	☐	☐	Fever Blisters	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Artificial Joint	☐	☐	Fosomax / Boniva	☐	☐	Liver Problems	☐	☐	Taken Redux / Fen-Phen
☐	☐	Asthma	☐	☐	Frequent headaches	☐	☐	Mental Health Treatment	☐	☐	Thyroid problems
☐	☐	Blood Transfusion	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Cancer-Chemotherapy	☐	☐	HIV +/AIDS	☐	☐	Pacemaker	☐	☐	

Is your child allergic to any of the following? Please mark Yes or No for each:

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Dental Anesthetics	☐	☐	Jewelry	☐	☐	Metals	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Erythromycin	☐	☐	Latex	☐	☐	Penicillin	☐	☐	Tetracycline
Other:														

Is your child taking any medications? If so, please list below, or provide a list:

Medication	Dose	When Taken	Condition	Medication	Dose	When Taken	Condition

Does your child have any other disease or medical condition we should be aware of? ☐ Yes ☐ No
If yes, please explain: _____

Has your child had any injuries to teeth, mouth, or head? ☐ Yes ☐ No
If yes, please explain: _____
Does your child need any special accommodations? _____

Child's Habits

How often does your child brush? _____
How often does your child floss? _____
Date of last dental visit _____
Previous Dentist _____
Phone Number _____
Is your child's water fluoridated? _____
Does your child take supplements? _____

Suck thumb / finger	☐ Yes	☐ No
Suck / bite lips	☐ Yes	☐ No
Bite / chew nails	☐ Yes	☐ No
Chew hard objects (pencils, etc.)	☐ Yes	☐ No
Grind teeth	☐ Yes	☐ No
Clench jaws	☐ Yes	☐ No

Authorization and 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 and/or other personal information. I authorize the dentist to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Yasuda, with my consent, to make a thorough diagnosis of my child's dental needs. I authorize the dental team of Dr. Yasuda to release information such as the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental 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 that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of parent or legal guardian Date