JENNIFER YEN, DDS @First Care Dental
Dental Care for Children from 0 to 21

CHILD'S NAME	NICKNAME	AGE	DATE OF BIRTH

SCHOOL	GRADE	REASON FOR VISIT

REFERRED TO THIS OFFICE BY (WE WISH TO THANK THEM)

MEDICAL HISTORY

1. CHILD'S PHYSICIAN

   CITY

   DATE LAST SAW PHYSICIAN

2. HAS YOUR CHILD HISTORY OF? (☑)
   - ❒ HEART TROUBLE OR MURMURS
   - ❒ RHEUMATIC FEVER
   - ❒ ALLERGIES
   - ❒ DRUG SENSITIVITIES
   - ❒ BRAIN INJURY
   - ❒ DIABETES
   - ❒ ASTHMA
   - ❒ EPILEPSY
   - ❒ SEIZURES/CONVULSIONS
   - ❒ KIDNEY/LIVER INVOLVEMENT
   - ❒ HEPATITIS
   - ❒ BLEEDING PROBLEMS
   - ❒ BLOOD DISORDERS
   - ❒ NONE

3. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? WHAT? ❒ YES ❒ NO

4. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? WHAT? ❒ YES ❒ NO

5. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT? ❒ YES ❒ NO

6. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT? ❒ YES ❒ NO

DENTAL HISTORY

1. CHILD'S FIRST DENTAL VISIT? ❒ YES ❒ NO

   PREVIOUS DENTIST

   CITY

   DATE LAST VISIT

2. NAME OF FAMILY DENTIST

   CITY

3. ANY INJURIES TO YOUR CHILD'S TEETH OR JAWS? (FALLS, BLOWS, CHIPS, ECT.) ❒ YES ❒ NO

4. HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE? ❒ YES ❒ NO

5. HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?

6. HISTORY OF:
   - ❒ THUMB SUCKING
   - ❒ FINGER SUCKING
   - ❒ LIP SUCKING
   - ❒ NAIL BITING
   - ❒ PACIFIER

7. HOW OFTEN DOES YOUR CHILD BRUSH?

   IS TOOTHBRUSHING SUPERVISED? ❒ YES ❒ NO

   BY WHOM?

8. IS DENTAL FLOSS USED? ❒ YES ❒ NO

9. DOES YOUR CHILD RECEIVE?
   - ❒ FLUORIDE VITAMINS
   - ❒ FLUORIDE TABLETS/DROPS
   - ❒ FLUORIDE WATER
   - ❒ NONE

OVER PLEASE

AUTHORIZATION, FAMILY INFORMATION & FINANCIAL RESPONSIBILITY

RESIDENCE ADDRESS		HOME PHONE
STREET		CELL PHONE
CITY	ZIP	WORK PHONE

MOTHER'S FULL NAME		ADDRESS IF DIFFERENT		OCCUPATION
SOC. SEC. NO.	BIRTHDATE:			WORK PHONE
EMPLOYED BY	BUSINESS ADDRESS			
NAME OF DENTAL INSURANCE CO.	GROUP NUMBER		EMPLOYEE NUMBER	DRIVER LICENSE NO.

FATHER'S FULL NAME		ADDRESS IF DIFFERENT		OCCUPATION
SOC. SEC. NO.	BIRTHDATE:			WORK PHONE
EMPLOYED BY	BUSINESS ADDRESS			
NAME OF DENTAL INSURANCE CO.	GROUP NUMBER		EMPLOYEE NUMBER	DRIVER LICENSE NO.

FIRST NAMES OF THE CHILD'S BROTHERS AND SISTERS AND THEIR AGES:

HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? ❐ YES ❐ NO IF YES, NAME:

NAME AND ADDRESS OF CLOSET RELATIVE OR FRIEND AND PHONE NUMBER:

*** IF THE FAMILY IS NOT LIVING TOGETHER, THE PARENT BRINGING THE CHILD IN IS RESPONSIBLE FOR THE CHILD'S ACCOUNT.**

I hereby aithorize Dr. Jennifer Yen and/or her associates to perform any and all treatment for my above named child and consent to such methods, drugs, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

SIGNATURE	RELATONSHIP TO CHILD	DATE

PLEASE NOTE:
1. **PAYMENT IS EXPECTED FOR SERVICE RENDERED AT THE TIME OF THE FIRST VISIT.**
2. **FINANCIAL ARRANGEMENTS FOR TREATMENT MAY BE MADE FOLLOWING DIAGNOSIS.**
3. **A CHARGE MAY BE MADE FOR BROKEN APPOINTMENTS UNLESS NOTIFIED 24 HOURS BEFORE.**