IRVINE PEDIATRIC DENTISTRY AND ORTHODONTICS

Shaul Yehezkel, D.M.D.

4902 Irvine Center Drive Suite 111 - Irvine,CA 92604

ipdodry@yahoo.com www.irvinepdo.com

Tel: (949)559-0674 Fax: (949)559-7909

TELL US ABOUT YOUR CHILD

Child's Name:_____ **Nickname:**_____

Birth Date:_____ **Age:** _____ **Gender:**_____ **Hobbies/Sports:**_____

School:_____ **Grade:** _____

Child's Address Home:_____ **City:**_____ **Zip:**_____

Referred by:_____ **Child's Hm#:**_____

Mother's Information: Married ☐ Single ☐ Partnered ☐ Separated ☐ Widowed ☐ Divorced ☐

Name _____ **Birth Date:**_____ **Wk#:**_____ **Ext:**_____

Hm#: _____ **Employer:**_____ **SS#:**_____ **DL#:**_____

Email address:_____ **Cellular Phone#**_____

Father's information: Married ☐ Single ☐ Partnered ☐ Separated ☐ Widowed ☐ Divorced ☐

Name _____ **Birth Date:**_____ **Wk#:**_____ **Ext:**_____

Hm#: _____ **Employer:**_____ **SS#:**_____ **DL#:**_____

Email address: _____ **Cellular Phone#**_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ **Relation:**_____

Billing Address: _____

PRIMARY DENTAL INSURANCE NO INSURANCE ☐

Insurance Co Name:_____ **Insurance Co Phone #:**_____

Insurance Co Address:_____

Group Plan #::_____ **Insurance ID #:**_____

Policy Owner's Name:_____ **Relationship to Patient:**_____

SECONDARY DENTAL INSURANCE NO INSURANCE ☐

Insurance Co Name:_____ **Insurance Co Phone #:**_____

Insurance Co Address:_____

Group Plan #::_____ **Insurance ID #:**_____

Policy Owner's Name:_____ **Relationship to Patient:**_____

What are the main concerns that you would like to address?_____

Has your child ever been evaluated or had orthodontic treatment before? Yes ☐ No ☐

Have there been any injuries on the face, mouth, teeth or chin? Yes ☐ No ☐

Have adenoids or tonsils been removed? Yes ☐ No ☐

Have you been informed that your child has any missing or extra permanent teeth? Yes ☐ No ☐

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? Yes ☐ No ☐

Does your child brush his/her teeth daily? Yes ☐ No ☐

Floss his/her teeth daily? Yes ☐ No ☐

Child's Physician:_____

Phone #:_____ Date of last visit:_____

Is your child currently under the care of a physician?

Yes ☐ No ☐

Please describe your child's current physical health:

Good ☐ Fair ☐ ☐ Poor

Please list all medications that your child is currently taking:

_____

Please list all medications/things your child is allergic to:

_____

_____

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Allergies to any medications
Y N Allergic to Latex/Metal
Y N Allergic to Plastic
Y N Any hospital stays
Y N Any operations
Y N Autism
Y N Artificial Bones/Joints/ Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicap/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N ADD/ADHD
Y N Hepatitis
Y N HIV+/AIDS
Y N Tuberculosis (TB)
Y N Liver/Kidney Problems
Y N Rheumatic/Scarlet Fever

Please discuss any medical problems that your child has had:

_____

_____

Has your child ever had any of the following medical/ dental problems?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

The Parent or Guardian who accompanies the child is responsible for payment

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

This office reserve the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services

If this office accepts insurance, I understand that I'm responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.
I understand that it is up to me to understand the rules and restrictions of my insurance policy.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform the necessary dental services I need

Responsible Party Signature:_____

Date:_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

_____

_____

_____

_____

Initials:_____

Date:_____