Steve C. Yang, DDS
Jessica K. Tsukamoto, DDS
1128 Kirkland Ave. NE.
Renton, WA 98056

Patient Information

Child's Name______________________________ Date of Birth__________
Home Address_________________________City __________Zip ________
Home Phone ________________ Emergency Contact Phone ____________

Father's Name_____________________________ Date of Birth__________
Work Phone___________Cell Phone__________Email_________________
How may we contact the father? Please check all that apply:
□Home □Work □Cell □Email □Text Message

Mother's Name ____________________________ Date of Birth__________
Work Phone __________ Cell phone__________Email_________________
How may we contact the mother? Please check all that apply:
□Home □Work □Cell □Email □Text Message

INSURANCE INFORMATION

Primary Insurance ___________________Employer___________________
Policy Holder_____________________Relationship to patient___________
SSN/ID # ________________________Group#_______________________

Secondary Insurance __________________ Employer _________________
Policy Holder_____________________Relationship to patient___________
SSN/ID# _________________________Group# ______________________

I grant permission to Steve C. Yang, DDS, Jessica K. Tsukamoto, DDS and team to perform treatment as deemed professionally necessary for patient named above. I understand that the use of dental anesthetics can involve risks.

FINANCIAL AGREEMENT All charges for treatment are my responsibility regardless of insurance coverage. I authorize payment of insurance benefits to Dr. Steve C. Yang, DDS.

____
Signature Date

____
Relationship to patient

DENTAL AND MEDICAL HISTORY

Please explain any concerns you have regarding patient for today's visit
____

Has your child been to a dental office previously? _______Date of Last Visit _________
Was it a positive experience? ________If not, explain ______________________________
Former Dentist__________________________ Date of Last X-Ray _________________

Has your child received any injuries to the mouth or teeth? ✐YES ✐NO
If yes, explain ____

Has your child complained of any tooth discomfort? ✐YES ✐NO
If yes, explain ____

Does your child have a speech problem? ✐YES ✐NO
If yes, explain ____

Does your child have the following oral habits?
✐ Thumb or finger sucking ✐Nail or lip biting ✐Pacifier ✐Nursing Bottle
Other, explain ____

MEDICAL HISTORY

Since conditions of the mouth can be hereditary, it is helpful to know if your child is adopted. ⊙YES ⊙NO
Child's Physician _________________________________Phone __________________
Date of Last Visit _____________ Nature of the visit? ___________________________
Has your child ever been hospitalized? ________Explain _________________________
Please describe any medical treatment including injuries, blood transfusions, pending surgery, special needs, or any other medical information we should be aware of that has not yet been discussed. ____
Does your child have any drug allergies? _______ Explain ________________________
Is your child taking any medications? _______ If yes, for what condition _____________
Medication Name____
PLEASE MARK THE FOLLOWING THAT APPLIES:

⊙ADD/ADHD	⊙Epilepsy	⊙Latex Sensitivity
⊙Asthma	⊙Fainting or Seizure	⊙Liver Condition
⊙Anemia	⊙Food Allergies	⊙Respiratory Condition
⊙Cancer	⊙Headaches	⊙Rheumatic Fever
⊙Cerebral Palsy	⊙Hearing Impaired	⊙Shortness of Breath
⊙Chicken Pox	⊙Heart Condition	⊙Sinus Problems
⊙Cough	⊙Hemophilia	⊙Skin Rash
⊙Diabetes	⊙Hepatitis	⊙Spina Bifida
⊙Disorders of the Blood	⊙HIV Positive	⊙Thyroid Disease
⊙Ear Infection	⊙Kidney Condition	⊙Tonsillitis
Other ___________________________		⊙Tuberculosis