Dallin C. Young, D.D.S. | Samuel Bailey, D.D.S.

# Children's Dentistry of Twin Falls

**Child's Name:** First:__________ Last:__________ Male Female
Preferred Name:__________ Birth date: __________ Age: __________
Home Address: __________
City, State, Zip Code: __________
Child lives with: (Circle one) Father Mother Both Other
Marital Status of parents: (Circle one) Married Single Divorced Separated Widowed

**GUARDIAN:** __________ (Circle One) Mother Father Other __________
Social Security Number:__________Birth date: __________
Employer: __________Work Phone: __________
Home Address if different than child's: __________
Home Phone:__________ Cell Phone: __________ Best time to contact: __________

**GUARDIAN:** __________ (Circle One) Mother Father Other __________
Social Security Number:__________Birth date: __________
Employer: __________Work Phone: __________
Home Address if different than child's: __________
Home Phone:__________Cell Phone:__________ Best time to contact: __________

**PERSON FINANCIALLY RESPONSIBLE:** __________
If other than parent, please write address: __________
Home Phone:__________ Cell Phone:__________Work Phone: __________

**PAYMENT OPTIONS:** Method of payment (please check one)
□ Cash, Check or credit card at time of service
□ Medicaid and co-pay if applicable
□ Insurance co-pay at time of service
□ CareCredit®

**PRIMARY DENTAL INSURANCE:**
Name: __________
Phone: __________
Policy #:__________
Subscriber: __________
Birth Date: __________

**SECONDARY DENTAL INSURANCE:**
Name:__________
Phone:__________
Policy #: __________
Subscriber: __________
Birth Date: __________

MEDICAL INSURANCE: __________

**REFERRAL INFORMATION:**
Whom may we thank for referring you to our office?
Dental Office (Doctor's Name):__________ Yellow Pages: __________
Another Patient (name):__________Friend (name): __________
School:__________Other: __________

**DENTAL HISTORY:**
Why is your child here today?__________
Is your child currently taking fluoride? __________How often? __________
Has your child been to the Dentist before? __________If so, date when last seen:__________
How was your child's experience? __________
Has your child had x-rays taken before?__________If so, date taken:__________
Is your child currently on the bottle? __________ Pacifier? __________Sippy Cup?__________
Nursing? __________ Thumb Sucking? __________Grinding?__________
Do you currently help your child brush and floss? __________
How often does he/she brush? __________

**MEDICAL HISTORY:**

Name of Physician: ____________________________Office: ________________________________

Date of last physical exam:______________________Any findings? ___________________________

Are your child's immunizations up to date? _____________________________________________

Is your child currently taking any medications?______If yes, what? __________________________

Is your child currently under the care of a physician for any reason? __________________________

If yes, what? ______________________________________________________________

Has you child ever had a traumatic medical or dental injury? _________________________________

If yes, what? ________________________________________Date: ____________________

Has your child ever been hospitalized?____________________________________________________

If yes, for what? ____________________________________Date: ____________________

Does your child have allergies/adverse reactions to medications, latex, or other substances?

If so, what? ________________________________________________________________

**DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?**
**PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:**

- □ ADHD
- □ AIDS
- □ Allergies________________
- □ Anemia
- □ Artificial joints
- □ Asthma
- □ Blood Disease
- □ Blood transfusion
  If yes, date:______________
- □ Behavioral/learning disorder
- □ Breathing/lung problems
- □ Cancer/Tumor
- □ Congenital birth defects
- □ Endocrine System
- □ Fainting
- □ Hearing/Sight
- □ Heart Murmur
- □ Heart Condition
- □ Head Injury
- □ Frequent headaches
- □ Kidney Disease
- □ Liver disease
- □ Mental disorder
- □ Mental/Physical development delay
- □ Multiple ear infections
- □ Tubes in ears
- □ Radiation treatment
- □ Respiratory treatment
- □ Respiratory problems
- □ Rheumatic Fever
- □ Seizures
- □ Tuberculosis
- □ Down Syndrome
- □ Vomiting/Diarrhea
- □ Pregnancy
  Due Date:____________
- □ Any other medial condition not listed? ________________
  __________________________
  __________________________
  __________________________

Because your child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental examination or treatment can be started by Dr. Young, Dr. Bailey or their staff. Our examination may include dental radiographs (x-rays) and other diagnostic aids, depending on your child's specific needs. Photographs for diagnosis, treatment planning and teaching purposes may be taken.

I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic reaction or unusual reaction to drugs, food, anesthetics, or other allergens; any body diseases, gum or skin reactions, abnormal bleeding, heart conditions; any other conditions related to my child's health, or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Your child's specific needs will be explained to you after the examination and prior to treatment.
We will also review with you the treatment that was performed when completed.
Consent is hereby given for diagnostic, restorative and surgical treatment for my child.

Signature: ____________________________________Date: ________________________________

Relationship to child: ______________________________________________________________

I have been given the opportunity to review the "HIPAA PRIVACY POLICY" Act.
*If you would like a copy to take with you please see the front desk*

Signature: ____________________________________Date: ________________________________

Email address: ____________________________________________________________________