Welcome!

Pediatric Dentistry at North Bethesda

Dr. Yuka Tanabe Yamagishi

Patient Information

Patient's First Name	Last Name	Preferred Name
Address		
City	State	Zip Code
Sex ☐ F ☐ M	Date of Birth	SSN
Whom may we thank for referring you to us?		

Parent/Guardian Information

Relationship	First Name	Last Name
Same address as child ☐	Date of Birth	SSN
Address (if different from child)		
Home Phone #	Cell Phone #	E-mail
Employer	Occupation	

Relationship	First Name	Last Name
Same address as child ☐	Date of Birth	SSN
Address (if different from child)		
Home Phone #	Cell Phone #	E-mail
Employer	Occupation	

Dental Insurance Information

Primary Plan Member Information:		
Name of Insured	Insured Date of Birth	Insured Employer
Insurance Co. Name	Patient's Member ID #	Group #
Insurance Co. Phone #	Insurance Co. Address	

Secondary Plan Member Information:		
Name of Insured	Insured Date of Birth	Insured Employer
Insurance Co. Name	Patient's Member ID #	Group #
Insurance Co. Phone #	Insurance Co. Address	

Release

I certify that the child is covered by _____ insurance company and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance **does not** cover. I hereby authorize Dr. Yuka Tanabe Yamagishi to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Initial:_____

I affirm that the information I have given is current to the best of my knowledge. It will be held in strictest confidence and it is my responsibility to inform this office of any changes in the child's medical status. I authorize the dental staff to perform the necessary dental services the child may need.

Initial: _____

Parent/Guardian Signature_____ Date _____

Please Continue on to the Next Page

Dental History

Reason for today's visit	
Former dentist's name	Phone #
Date of last exam/cleaning	X-Rays
Does the child require antibiotics before dental treatment?	
Is the child's water fluoridated?	Is the child taking fluoride supplment?
Has the child ever had a serious/difficult problem associated with previous dental work?	
Who is responsible of the child's oral hygiene?	
Brushing x_____per day	Flossing x_____per day

Medical History

Child's physician's name	Phone #	Date of last visit
Is the child currently under the physician's care? Y ☐ N ☐ If yes, please describe		
Please describe the child's current physical health: Good ☐ Fair ☐ Poor ☐		
List the medications the child is currently taking, if any:		
Are the child's immunization current?		

Circle if the child has/had any of the following:

ADD/ADHD	Yes	No	Hepatitis or Liver Problems	Yes	No
AIDS/HIV	Yes	No	High Blood Pressure	Yes	No
Anemia	Yes	No	Hospital Stays/ Operations	Yes	No
Artificial Bone/Joints/Valves	Yes	No	Kidney Disease	Yes	No
Asthma or Respiratory Disease	Yes	No	Learning Disability	Yes	No
Atopic	Yes	No	Low Blood Pressure	Yes	No
Autism Spectrum Disorder	Yes	No	Lupus	Yes	No
Blood Disease	Yes	No	Material Allergies	Yes	No
Cancer	Yes	No	Measles	Yes	No
Cerebral Palsy	Yes	No	Mitral Valve Prolapse	Yes	No
Chicken Pox	Yes	No	Mononucleosis	Yes	No
Congenital Heart Disease	Yes	No	Prosthetics	Yes	No
Convulsions/Epilepsy/Seizures	Yes	No	Respiratory Disease	Yes	No
Cough	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Diabetes	Yes	No	Shortness of Breath	Yes	No
Disability	Yes	No	Sinus Problems	Yes	No
Food Allergies	Yes	No	Spina Bifida	Yes	No
Headaches	Yes	No	Thyroid Disease	Yes	No
Hearing Impairment	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No			
Hemophilia/Abnormal Bleeding	Yes	No			
Hemoptysis (Cough Up Blood)	Yes	No			

Is there anything you would like to discuss with the doctor in private? Yes ☐ No ☐

Please discuss any serious medical conditions the child experiences/experienced_____

Circle if the child has/had any of the following:

Breast Fed/Chewing on objects	Yes	No	Speech Problem	Yes	No
Clenching/Grinding Teeth	Yes	No	Thumb/Finger Sucking	Yes	No
Lip Sucking/Biting	Yes	No	Tongue/Cheek/Nail Biting	Yes	No
Mouth Breathing	Yes	No	Tongue Thruster	Yes	No
Nursing Bottle Habit	Yes	No	Usage of Pacifier	Yes	No