Yashashwini Marappa, DDS (Dr.Yashi)
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Healthy Smiles Begin Here!

PATIENT INFORMATION

Name:_____ Nickname:_____ DOB:_____ Gender: ☐ M ☐ F
Street Address:_____ City:_____ State:_____ Zip:_____
Primary number for appointment confirmations: (___) ___-____
Who is accompanying the child today?
Name:_____ Relation: ☐ Biological ☐ Adopted ☐ Foster ☐ Nanny ☐ Other: _____

Is your child a ward of the state? ☐ Yes ☐ No If yes, case worker's contact information: _____

PARENT INFORMATION

Who does the patient live with? ☐ Guardian 1 & 2 ☐ Guardian 1 ☐ Guardian 2 ☐ Other: _____

GUARDIAN (I)

Name:_____ Gender: ☐ M ☐ F
DOB:_____ SS#: _____
Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed
Home: (___) ___-____ Cell: (___) ___-____
Email: _____
☐ *Check box if Address is same as patient's listed above.*
Street Address: _____
City:_____ State:_____ Zip:_____
Employer:_____
Work: (___) ___-____

GUARDIAN (II)

Name:_____ Gender: ☐ M ☐ F
DOB:_____ SS#: _____
Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed
Home: (___) ___-____ Cell: (___) ___-____
Email: _____
☐ *Check box if Address is same as patient's listed above.*
Street Address: _____
City:_____ State:_____ Zip:_____
Employer:_____
Work: (___) ___-____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____
DOB:_____ SS#: _____
Employer:_____
Phone: (___) ___-____
Insurance Co.: _____
Street Address: _____
City:_____ State:_____ Zip:_____
Phone: (___) ___-____ Group/Policy #: _____
_____
I.D. #: _____

SECONDARY COVERAGE

Name of Insured: _____
DOB:_____ SS#: _____
Employer:_____
Phone: (___) ___-____
Insurance Co.: _____
Street Address: _____
City:_____ State:_____ Zip:_____
Phone: (___) ___-____
Group or Policy #: _____
I.D. #: _____

REFERRAL INFORMATION

☐ Sibling:_____
☐ Friend:_____
☐ Pediatrician/Physician:_____
☐ Dentist/Dental Office:_____
☐ Insurance:_____
☐ School/Daycare:_____
☐ Community Event:_____

☐ Google
☐ Website
☐ Facebook
☐ Angie's List
☐ Print Ad (Magazine, Newspaper, etc.): _____
☐ Media Ad (Radio, Movie Theater, etc.): _____
☐ Other: _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay

Has your child ever been to the dentist? ☐ Yes ☐ No

(If Yes) Previous/Present Dentist:_____ **Date Last Exam:**_____ **Date Last X-Rays:** _____

Do you think your child will react well to treatment? ☐ Yes ☐ No

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit: _____

_____

DENTAL HABITS

Does your child currently... (Check all that apply)

❑ Suck Thumb/Finger ❑ Suck/Bite Lips ☐ Bite/Chew Nails ❑ Tongue Thrust ❑ Bottle Feed

❑ Use Pacifier ❑ Tongue/Cheek Chew ☐ Clench/Grind Teeth ❑ Mouth Breather ❑ Breast Feed

HYGIENE ROUTINE

(check all that apply)

❑ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child:____/day ☐ Snack between Meals - Type of snacks:

❑ Fluoride Mouthwash ☐ Dental Floss:___/week ☐ Brushing by Parent:____/day _____

MEDICAL HISTORY

Are immunizations current? ☐ Yes ☐ No

Child's Physician:_____ **Phone: (____)____-_____ Date Last Exam:** _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain)**:** _____

_____

Current Medications: _____

Is your child followed by a specialist? ☐ Yes ☐ No **If yes, provide name & contact information:** _____

Has your child been diagnosed and/or treated for any of the following (check all that apply)

❑ Blood Disorder/Anemia
❑ Abnormal Bleeding/Hemophilia
❑ Immune Disorder/HIV/AIDS
❑ Cancer/Tumor/Leukemia
❑ Heart Murmur/Defect/Surgery
❑ Epilepsy/Seizures/Convulsions
❑ Cerebral Palsy
❑ Cystic Fibrosis
❑ Kidney Problems
❑ Liver Disease/Jaundice/Hepatitis
❑ Diabetes
❑ Sickle Cell Trait
❑ Stomach/GI Disorders
❑ Tuberculosis (TB)
❑ Asthma/Reactive Airway
❑ Tonsillitis
❑ Congenital Birth Defects
❑ Premature/Low Birth Weight
❑ Cleft Lip/Palate
❑ Autism Spectrum
❑ ADD/ADHD
❑ Eating Disorder
❑ Speech Disorder
❑ Vision Problems
❑ Hearing Problems
❑ Deaf
❑ Mental/Cognitive/Social Delay
❑ Other Condition (specify): _____

ALLERGIES:

❑ Drug: _____
❑ Food: _____
❑ Seasonal
❑ Hives
❑ Latex
❑ Other (specify): _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need.

I understand that Sunny Smiles Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review.

I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Sunny Smiles Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Signature:_____ **Date:** _____