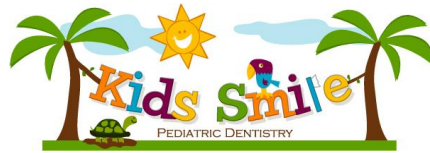


11700 South Street  
Suite 202  
Artesia, CA 90701



office (562)924-5437  
fax (562)296-6540

IlJoon Kim, D.M.D

Kay Wangpichit, D.D.S.

### Welcome Kids Smile Pediatric Dentistry

We are pleased to welcome you and your child to our practice. Our primary goal is to make every visit fun & educational. Our practice is based on preventative dental care. With proper oral health care, your child will have a beautiful smile that lasts a lifetime.

Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

### Your Child

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
Nickname: \_\_\_\_\_ O Male O Female  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Telephone: (\_\_\_\_\_) \_\_\_\_\_  
Siblings that we treat: \_\_\_\_\_

Who may we thank for your referral? \_\_\_\_\_

Who is Accompanying the Child Today?

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Do you have full legal custody of this child?  Yes  No

Staff Only:

### Health History

Child's Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Is the child currently under the care of a physician?  Yes  No  
When was your child's last check-up with pediatrician? \_\_\_\_\_  
Are Immunizations Current?  Yes  No  
Please describe the child's current physical health:  Good  Fair  Poor

Please list all drugs the child is currently taking:  
\_\_\_\_\_

Please list all drugs the child is allergic to:  
\_\_\_\_\_

Has your child ever had any of the following conditions:

- |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|
| Yes                   | No                    | Yes                   | No                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
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| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
- Anemia  
Sickle Cell Anemia or Trait  
Abnormal Bleeding  
Asthma or Lung Problems  
Heart Condition / Surgery  
Heart Murmur  
Hearing Impairment  
Eye Problem  
Immunologic Disorder, AIDS / HIV+  
Kidney Disease or Transplant  
Liver Disease or Transplant  
Hepatitis or Jaundice

- Yes No
- Rheumatic Fever
  - High or Low Blood Pressure
  - Seizures or Epilepsy
  - Diabetes
  - Thyroid Disorder
  - Implanted Shunts, Pins or Rods
  - Latex Allergy or Sensitivity
  - Chicken Pox, Measles, Mumps
  - Cancer / Tumors
  - Seasonal Allergies, Hay Fever

- Yes No
- Stomach / GI Disorder
  - Tuberculosis or Previous Positive Test
  - Currently Pregnant
  - Drug or Alcohol Abuse
  - Handicaps or Disabilities
  - Emotional or Behavioral Problems
  - ADD, ADHD or Hyperactivity
  - Autistic Spectrum Disorder
  - Learning Disability
  - Congenital Birth Defects / Syndrome

Any other condition(s) that we should be aware of: \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No  
 If yes, when? \_\_\_\_\_ Please describe: \_\_\_\_\_

Has your child had any operations?  Yes  No  
 If yes, when? \_\_\_\_\_ Please describe: \_\_\_\_\_

Was general anesthesia or sedation used?  Yes  No  
 Any complication(s)? If yes, please describe: \_\_\_\_\_

### Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_  
 If not, how long since the last visit to the dentist? \_\_\_\_\_  
 Name of previous dentist: \_\_\_\_\_  
 Were any x-rays taken at previous dental visits? \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Has the child ever had a serious or difficult problem(s) associated with previous dental work?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

How would you predict your child's behavior to be?  
 Cooperative  Fearful  Defiant  Don't know

Does the child have any of the following habits / conditions?

Yes	No		Yes	No
<input type="radio"/>	<input type="radio"/>	Nursing Bottle Habits	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	Pacifier	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	Mouth breathing	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	Pain to jaw or joint	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>

Does the child brush his/her teeth daily?  Yes  No  
 Floss his / her teeth daily?  Yes  No  
 Use mouthwash?  Yes  No  
 Is the child's water fluoridated?  Yes  No  
 Is the child taking fluoride supplements?  Yes  No  
 Does your child play any contact sport?  Yes  No

Drs. Only:

Father  Guardian  
 Responsible for Account  
Marital Status:  
 Married  Single  Divorced  
 Separated  Widowed

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Mobile Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
\_\_\_\_\_  
Work Phone: \_\_\_\_\_

Primary Dental Insurance  
Policy Holder's Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
ID #: \_\_\_\_\_  
Group (Plan, Policy)#: \_\_\_\_\_

Mother  Guardian  
 Responsible for Account  
Marital Status:  
 Married  Single  Divorced  
 Separated  Widowed

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Mobile Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
\_\_\_\_\_  
Work Phone: \_\_\_\_\_

Secondary Dental Insurance  
Policy Holder's Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
ID #: \_\_\_\_\_  
Group (Plan, Policy)#: \_\_\_\_\_

### Consent for Care

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

I authorize the dental staff to perform the necessary dental services my child may need. This will include examinations, x-rays, cleanings, and fluoride applications.

I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I request that my insurance company pay directly to the dentist. **I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.**

In the event I must cancel my child's appointment, it is important that I give your office 24 hours notice. If I do not give prior notification, I will be charged a \$25.00 broken appointment fee.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

## Authorization for Signature on File

### Patient Release of Information and Acknowledgement of Financial Responsibility.

I, \_\_\_\_\_ (print your name), hereby authorize Wangpichit and Kim Professional Dental Corporation (DBA Kids Smile Pediatric Dentistry) to affix my name to any and all claims and documents as related to any and all health benefits due me. I understand that any services not covered by my insurance will become solely my responsibility.

To the extent permitted under applicable law, I authorize release of any information relating to the claim. This "Signature on File" will be valid from this date until withdrawn. A photocopy of this document may act as an original.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

## Insured Assignments of Benefits

I, \_\_\_\_\_ (print your name), hereby authorize Wangpichit and Kim Professional Dental Corporation (DBA Kids Smile Pediatric Dentistry) to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents.

I hereby authorize the payment of dental benefits otherwise payable to me, directly to Kids Smile Pediatric Dentistry. This "Signature On File" will be valid for one year from this date. A photocopy of this copy may act as an original.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_