Welcome!

Moe Yazdi, DDS, PH.D
Orthodontic Specialist

1. ABOUT YOUR CHILD:

Date: _____

CHILD'S NAME: _____ CHILD'S NICKNAME:_____

DATE OF BIRTH: _____ AGE: _____ MALE ___FEMALE_____

SCHOOL:_____ GRADE: _____

CHILD'S ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

REFERRED BY: _____ EMAIL:_____

2. FAMILY INFORMATION:

WHO IS ACCOMPANYING THIS CHILD TODAY: _____

NAME: _____ LEGAL CUSTODY: YES _____ NO_____

SIBLINGS: YES ____ NO ____ AGES: _____ _____ _____

MOTHERS NAME: _____SS#_____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: ( )_____ CELL: ( ) _____

WORK: ( ) _____

EMPLOYER: _____ ADDRESS: _____
_____ HOW LONG EMPLOYED: _____

FATHERS NAME: _____SS#_____

ADDRESS IF DIFFERENT FROM ABOVE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: ( )_____ CELL: ( ) _____

WORK: ( ) _____

3. CHILD'S DENTAL INFORMATION

Please check any problems your child may have below:

____ Discomfort, clicking or popping of jaw ____ Lost or broken fillings

____ Stained teeth ____ Red, swollen or bleeding gums ____Teeth grinding ____TMJ/TMD

____ Lock jaw ____ Sensitive teeth or gums ____ Ringing in ears

____ Bad breath ____ Blisters/sores in or around mouth ____broken/chipped tooth

____ Loose teeth Other:_____

Does Child require pre-medication? ____Yes ____No ____Unknown

LAST DENTAL EXAM: _____

4. CHILD'S MEDICAL HISTORY

Is Child taking any of the following medications? ___ Aspirin
___Pain Relievers: If so, names:_____
___ Ritalin ___ Stimulants: If so, names:_____
___ Blood thinners ___Tranquilizers ___Insulin ___Muscle relaxers
Other:_____

Childs General Doctor: _____ Phone # _____

Does child have or has ever had any of the following diseases or medical conditions?

Y N - Heart Murmur	Y N -Tonsillitis	Y N - High / Low Blood pressure
Y N - Rheumatic fever	Y N - Respiratory issues	Y N - Hepatitis
Y N - Artificial Heart Valve	Y N – Asthma	Y N -Artificial bones/joints/implants
Y N – Congenital Heart Defect	Y N – Difficulty breathing	Y N – Organ problems
Y N – Scarlet fever	Y N – Leukemia	Y N – HIV/AIDS/ARC
Y N – Surgeries/Operations	Y N – Anemia	Y N – Tuberculosis (TB)
Y N – Cancer/Tumors	Y N – Diabetes	Y N – Hypoglycemia
Y N – Psychiatric problems	Y N – Chemotherapy	Y N – Hemophilia
Y N – Hyper active	Y N – Abnormal bleeding	Y N – Fainting/Seizures/Epilepsy

If answered YES to any conditions above, please explain:_____
_____

ALLERGIES:
____Latex ____Penicillin / Amoxicillin ____Tetracycline ____ Dental Anesthetics

____ Aspirin ____ Foods: _____

Does child wear contact lenses: ____ Yes ____ No
Does child do any of the following? ____ Thumb or finger sucking ____Tongue thrusting/sucking

____ Heavy snoring ____ Mouth breathing ____ Lip biting/sucking

5. DENTAL INSURANCE INFORMATION:

Responsible Party:
Name: _____ Relationship to patient: _____

~Primary:
Insurance Company: _____

Group#: _____ Member #: _____

~Secondary:
Insurance Company: _____

Group#: _____ Member#: _____

Subscriber Name (If different from above): _____

Date of Birth _____SS#: _____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s), have insurance coverage with:_____ _____ insurance company.
And assign directly to ***Dr. Moe Yazdi*** all insurance benefits pertaining to the treatment of above patient:

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment.
Before and after photos and x-rays will be taken.
I authorize the use of my photos/x-rays to be shown to other doctors or insurance companies.
~I **do** authorize the use of my photos for display, to show as examples of dental work performed by Dr. Yazdi and staff to other patients.
_____ (Initials)
~I **do not** authorize the use of my photos for display.
_____(Initials)

_____ Date:_____
Signature