Yost Pediatric Dentistry ● 102 Palo Alto Rd #400. San Antonio, TX 78211 ● (210)924-8770

Patient Information

Patient's Name_____ Preferred Name_____ Sex: M F DOB_____
First MI Last

Address _____
Street City State Zip

Is the person bringing in the patient to the dental visit the legal guardian? □ Yes □ No Relationship to Patient_____

Name of Parent/Guardian_____Parent/Guardian DOB_____ Sex: M F

Primary Phone(_____)_____-_____ Home Phone(_____)_____-_____ Email_____

Preferred Method of Contact: Phone _____Text _____ Email _____ Mail _____

Is your child covered by dental insurance? □ Yes □ No If yes, what insurance? _____

Dental/Medical History

What is the reason for your child's visit today? _____

When was the last time your child was seen by a dentist? _____Where? _____

Is your child being referred by another dentist? □ Yes □ No If yes, by who? _____

Has your child been seen in our office before? □ Yes □ No

Does your child complain of tooth or mouth pain? □ Yes □ No

Has your child has any accident involving his/her teeth? □ Yes □ No

Does your child suck his/her thumb, finger or pacifier? □ Yes □ No

Has your Child ever had a bad dental experience? □ Yes □ No

Child's Primary Care Physician _____Phone Number_____

Other Doctor/Specialist_____Phone Number_____

Name of Medication	Dose	Frequency

Is your child taking any medications? □Yes □No (If yes, fill in box)

Is your child allergic to a medicine or anything else? □Yes □No

If yes, please explain: _____

_____

Has your child ever been hospitalized? □ Yes □No

If yes, please explain: _____

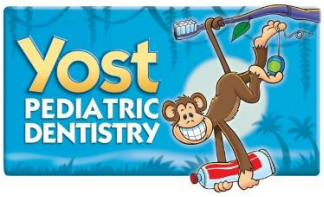
Has your child ever had a problem with or received treatment for any of the following?

Yes	No		Yes	No		Yes	No	
□	□	Blood, Circulation	□	□	GI System- Stomach, Intestine	□	□	Muscles
□	□	Bones	□	□	Kidneys, Bladder, Genitals	□	□	Nervous System
□	□	Endocrine Glands	□	□	Heart	□	□	Skin
□	□	Eyes, Ears, Nose, Throat	□	□	Lungs	□	□	Tonsils, Adenoids

Has your child ever been diagnosed with any of the following conditions?

Yes	No		Yes	No		Yes	No	
□	□	Anemia	□	□	Diabetes	□	□	Intellectual Disability
□	□	Asthma	□	□	Emotional/Nervous Disorder	□	□	Orthopedic Problem
□	□	Brain Injury	□	□	Eye Problem	□	□	Pneumonia
□	□	Bleeding Problem	□	□	Hearing Loss	□	□	Pregnancy
□	□	Cancer	□	□	Heart Murmur	□	□	Rheumatic Fever
□	□	Cerebral Palsy	□	□	Hepatitis	□	□	Sickle Cell Anemia
□	□	Seizures	□	□	HIV or AIDS	□	□	Spina Bifida
□	□	Developmental Delay	□	□	Leukemia	□	□	Syndrome _____

Does your child have any other medical condition not covered above? □Yes □No If yes, explain _____



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Consent to Treat and Acknowledgement of Receipt of Notice of Privacy of Practice

Welcome to Yost Pediatric Dentistry! We truly appreciate you choosing us to meet your child's dental needs. At Yost Pediatric Dentistry we strive to deliver the best dental care for our young patients.

At Yost Pediatric Dentistry we politely request that children come back by themselves unless they are too young or have special needs. Our experience has demonstrated that our patients generally behave better and doctor-patient communication improves. Our Philosophy includes teaching children how to become good dental patients who can enjoy a life time of oral health. The caring staff at Yost Pediatric Dentistry has many years of experience alleviating children's fears and helping to make their dental visit enjoyable. If you feel uncomfortable with our policy, we will be glad to discuss other treatment approaches for your child or suggest seeing another dentist with whom you may feel more comfortable.

During your child's initial or periodic visits, Dr. Michael Yost, Dr. Clyde Yost or Dr. Lina Cardenas will examine your child's teeth, and either Dr. Michael Yost, Dr. Clyde Yost, Dr. Lina Cardenas, a registered dental hygienist or a registered dental assistant will clean your child's teeth and apply fluoride treatment. To aide in the detection of dental caries or other oral pathology, x-rays will usually be taken. In addition, a proven preventive measure against pit and fissure caries, the dental sealant, may be applied. Dr. Michael Yost, Dr. Clyde Yost or Dr. Lina Cardenas will discuss the exam findings and any recommended treatment with you.

_____ Initial — I have read the above statement and I authorize Dr. Michael Yost, Dr. Clyde Yost or Dr. Lina Cardenas and staff at Yost Pediatric Dentistry to perform diagnostic procedures including but not limited to an oral exam, radiographs and photographs. In addition, I consent to preventative dental procedures deemed appropriate including a dental prophylaxis, sealant placement and fluoride treatment.

_____ Initial — I have received a copy of this Notice of Privacy of Practices. *You may refuse to sign this Acknowledgement form.*

_____ _____

Parent/Guardian Printed Name *Date* *Patients Name* *DOB*

_____ _____

Parent/Guardian Signature *Relationship to Patient*

Office Use Only
Written Acknowledgement was not obtained because:
□Patient's parent/legal guardian refused to sign
□Emergency situation
□Unable to communicate with patient's parent/legal guardian
□Other_____