11700 South Street
Suite 202
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office (562)924-5437
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IlJoon Kim, D.M.D. Kallaya Wangpichit, D.D.S., M.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: _____
Primary telephone: (_____) _____

Who may we thank for your referral? _____

Who is Accompanying the Child Today?
Name: _____
Relationship: _____
Do you have full legal custody of this child? O Yes O No

Staff Only:

Health History

Child's Physician: _____Phone: (___) _____
Is the child currently under the care of a physician? O Yes O No
When was your child's last check-up with pediatrician? _____
Are Immunizations Current? O Yes O No
Please describe the child's current physical health: O Good O Fair O 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	
O	O	Anemia	O	O	Hearing Impairment
O	O	Sickle Cell Anemia or Trait	O	O	Eye Problem
O	O	Abnormal Bleeding	O	O	Immunologic Disorder, AIDS / HIV+
O	O	Asthma or Lung Problems	O	O	Kidney Disease or Transplant
O	O	Heart Condition / Surgery	O	O	Liver Disease or Transplant
O	O	Heart Murmur	O	O	Hepatitis or Jaundice

Yes	No		Yes	No	
O	O	Rheumatic Fever	O	O	Stomach / GI Disorder
O	O	High or Low Blood Pressure	O	O	Tuberculosis or Previous Positive Test
O	O	Seizures or Epilepsy	O	O	Currently Pregnant
O	O	Diabetes	O	O	Drug or Alcohol Abuse
O	O	Thyroid Disorder	O	O	Handicaps or Disabilities
O	O	Implanted Shunts, Pins or Rods	O	O	Emotional or Behavioral Problems
O	O	Latex Allergy or Sensitivity	O	O	ADD, ADHD or Hyperactivity
O	O	Chicken Pox, Measles, Mumps	O	O	Autistic Spectrum Disorder
O	O	Cancer / Tumors	O	O	Learning Disability
O	O	Seasonal Allergies, Hay Fever	O	O	Congenital Birth Defects / Syndrome

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

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

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

Was general anesthesia or sedation used? O Yes O 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? O Yes O No
If yes, please explain: _____

Has the child ever had a serious or difficult problem(s) associated with previous dental work? O Yes O 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?
O Cooperative O Fearful O Defiant O Don't know

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

Yes	No		Yes	No	
O	O	Nursing Bottle Habits	O	O	Lip Sucking / Biting
O	O	Pacifier	O	O	Nail Biting
O	O	Mouth breathing	O	O	Thumb / Finger Sucking
O	O	Pain to jaw or joint	O	O	Teeth grinding

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

Drs. Only:

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

Name: _____
Home Phone: _____
Mobile Phone: _____
Employer: _____
Occupation: _____
Work Phone: _____

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

Name: _____
Home Phone: _____
Mobile Phone: _____
Employer: _____
Occupation: _____
Work Phone: _____

Please provide the following to enhance our office & patient communication:

- Email address: _____
- Text messages for appointment reminder: O Allow O Disallow
  Primary mobile phone number for text message: _____

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 hereby authorize Kids Smile Pediatric Dentistry and staff to release all contact information (including but not limited to: name, address, email, telephone number, etc.) to Demand Force regarding myself and/or my dependent children. It will be used only to help improve communication between Kids Smile Pediatric Dentistry and myself such as to: request appointments online, confirm appointments via email, receive text message appointment reminders, submit patient satisfaction surveys and refer friends online. I understand that the information released **will be held in strictest confidence** between these parties and that it will be viewed only by those involved. I further release and hold harmless both Kids Smile Pediatric Dentistry and Demand Force from any and all liability that may potentially result from the release and/or use of such information.

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.**

Pictures or video recordings are not allowed in our office due to privacy issues.

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 _____

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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 _____