BUENA VISTA ORTHODONTICS
MERILYNN YAMADA, D.D.S. & ASSOCIATES
2625 W. Alameda Ave., Suite 220 | Burbank, CA 91505
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Health History Form—18 years and under

Please fill out this form and bring to your first appointment.
Thank you for choosing us for your orthodontic care!

_____ _____ _____
Patient First **Middle** **Last**

Patient Information: Date: ___ / ___ / ___ **Who may we thank for telling you about our office?**_____

Prefers to be called: _____ Gender: □ M □ F Birthdate: ____ /____ /_____ Age: _____ School: _____ Grade:_____

Graduates in (yrs) _____ Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ - _____ Pt's Cell Phone: (_____) _____ - _____ _____Pt's Email: _____

Dentist: _____ City:_____ Phone: (_____) _____ - _____ Yrs. with DDS_____ Last visit: ___ /___ /_____

Name of Physician: _____ City: _____ Phone: (_____) _____ - _____

Other medical or dental specialists seen: _____ City:_____ Phone: (_____) _____ - _____

Other siblings/relatives seen by Dr. Yamada: _____ Relationship/s: _____

MOTHER or □ Legal Guardian: _____ Prefers to be called: _____ Financially Responsible for Pt: □ Yes □ No

Status: □ Single □ Married □ Remarried □ Separated □ Divorced □ Widowed □ Other:_____

□ Address same as patient Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Email: _____ Birthdate: ___ /___ /_____

SSN: _____ - ____ - _____ Driver's License #: _____ Best way to reach me: □ Phone □ Email □ Text □ All □ Other_____

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

Dental Insurance? □No □Yes Provider: _____ Coverage:_____ Group No:_____ Subscriber No:_____

Medical Insurance? □No □Yes Provider: _____ Coverage:_____ Group No:_____ Subscriber No:_____

Orthodontic Insurance? □No □Yes Maximum: $_____ Flex plan: □ No □ Yes Deadline to file for next year: _____

FATHER or □ Legal Guardian: _____ Prefers to be called: _____ Financially Responsible for Pt: □ Yes □ No

Status: □ Single □ Married □ Remarried □ Separated □ Divorced □ Widowed □ Other:_____

□ Address same as patient Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Email: _____ Birthdate: ___ /___ /_____

SSN: _____ - ____ - _____ Driver's License #: _____ Best way to reach me: □ Phone □ Email □ Text □ All □ Other_____

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

Dental Insurance? □No □Yes Provider: _____ Coverage:_____ Group No:_____ Subscriber No:_____

Medical Insurance? □No □Yes Provider: _____ Coverage:_____ Group No:_____ Subscriber No:_____

Orthodontic Insurance? □No □Yes Maximum: $_____ Flex plan: □ No □ Yes Deadline to file for next year: _____

FINANCIAL RESPONSIBILITY (if other than above): □ Step Parent □ Grandparent □ Other: _____ Name:_____

□Address same as patient Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Email: _____ Birthdate: ___ /___ /_____

SSN: _____ - ____ - _____ Driver's License #: _____ Best way to reach me: □ Phone □ Email □ Text □ All □ Other_____

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

ADDITIONAL EMERGENCY CONTACT: Name_____Relationship to patient:_____

Address: _____City_____State_____ Zip_____

Phone: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____ Email: _____
Home Cell Phone Work

Best way to reach me: □ Phone □ Email □ Text □ All □ Other_____

Last Revised: 06/13/2010