COLBY PACIFIC
FAMILY DENTISTRY

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Please answer all questions on **both** sides, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. *Thank You.*

CHILD'S NAME _____ Nickname _____

☐ Male ☐ Female ☐ Other Birthdate _____ Age ____

What hobbies or interests does your child have? _____

_____

☐ **Stepfather** ☐ **Guardian**

FATHER'S NAME _____ Birthdate ___/___/___ Social Security No. ___-___-____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Father's Occupation _____ Employer _____ Work Phone _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

❑ **Stepmother** ❑ **Guardian**

MOTHER'S NAME _____ Birthdate ___/___/___ Social Security No. ___-___-____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Mother's Occupation _____ Employer _____ Work Phone _____

With whom does this child reside? _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Insurance Co. _____ Group # _____	Insurance Co. _____ Group # _____
Insured Birthdate ___/___/___	Insured Birthdate ___/___/___
Employee's S.S. No. ___-___-____	Employee's S.S. No. ___-___-____

Person responsible for child's account: _____ Phone No. _____

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IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Phone _____ Work Phone _____

Relationship to Patient _____ Closest Relative _____ Phone No. _____

Family Physician _____ Phone No. _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Is this your child's first dental visit? ☐ Yes ☐ No
Previous Dentist's Name? _____
Date of last visit: _____
Does your child feel nervous about having dental treatment? ☐ Yes ☐ No
Has your child ever had a bad dental experience? ☐ Yes ☐ No
Has your child been seen by an orthodontist? ☐ Yes ☐ No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? ☐ Yes ☐ No
Has your child ever been premedicated for dental work? ☐ Yes ☐ No
Does your child receive fluoride in vitamins, tablets, or water? ☐ Yes ☐ No
Is your child having any pain or discomfort at this time? ☐ Yes ☐ No

HEALTH HISTORY

Has your child been hospitalized during the past 2 years? ☐ Yes ☐ No
If yes, what for? _____

Has your child been under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No
Is your child currently taking any medications? ☐ Yes ☐ No
If yes, please list: _____

Is your child taking any prescriptions or OTC medications? ☐ Yes ☐ No
If yes, please list: _____

Please list any serious medical condition(s) that your child has or has had: _____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Angina Pectoris	☐	☐	ADHD	☐	☐	Radiation Treatment	☐	☐	Frequent Headaches
☐	☐	Heart Disease / Attack / Stroke	☐	☐	Sickle Cell Disease	☐	☐	Ulcers	☐	☐	Fever Blisters / Cold Sores
☐	☐	Heart Failure	☐	☐	Blood Transfusion / Anemia	☐	☐	Emphysema / Asthma	☐	☐	Fainting / Dizzy Spells
☐	☐	High / Low Blood Pressure	☐	☐	Bruise Easily	☐	☐	Cough / Tuberculosis (TB)	☐	☐	Epilepsy / Seizures
☐	☐	Congenital Heart Defect	☐	☐	Hemophilia	☐	☐	Arthritis / Rheumatism	☐	☐	Hay Fever / Sinus Trouble
☐	☐	Heart Murmur / Rheumatic Fever	☐	☐	Liver Disease / Yellow Jaundice	☐	☐	Cortisone Medicine	☐	☐	Allergies / Hives
☐	☐	Heart Surgery	☐	☐	Kidney Failure/Dysfunction	☐	☐	A.I.D.S. / H.I.V.	☐	☐	Shingles/Chicken Pox
☐	☐	Heart Pacemaker	☐	☐	Thyroid Disease	☐	☐	Hepatitis: A B C **(circle one)**	☐	☐	Nervousness
☐	☐	Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Pain in Jaw Joint	☐	☐	Psychiatric Treatment
☐	☐	Diabetes	☐	☐	Chemotherapy / Cancer	☐	☐	Artificial Joints (Hip, Knee)	☐	☐	Sleep Apnea

Is your child allergic to or reacted adversely to any of the following?

☐ Antibiotics ☐ Aspirin
☐ Codeine ☐ Latex
☐ Metals / Jewelry ☐ Local/Dental Anesthetic

Does your child have allergies to any other medications or substances? If yes, please list:

_____
_____
_____

Sleep/Airway Issues

Does the patient tend to be a mouth-breather? ☐ Yes ☐ No
Does the patient seem rested in the moring? ☐ Yes ☐ No
Is the patient often hyperactive during the day or have difficulty concentrating? ☐ Yes ☐ No
Does the patient often snore at night? ☐ Yes ☐ No
Does the patient sleep-walk or have night terrors? ☐ Yes ☐ No
Has the patient seen an Ear, Nose & Throat specialist? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 Dr. Eggenberger and/or dental staff to perform the necessary dental services my child may need.

Signature _____ Date _____
Parent/Guardian

Signature _____ Date _____
Doctor