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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 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. _____

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:

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

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

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals / Jewelry | <input type="checkbox"/> 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 morning? 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