

CLASSIC CHILDRENS DENTISTRY

T.J. EBERHARDT D.M.D., LTD

Health and History Form

About your child

Name Age ?M?F Date of Birth

Address City State Zip

Patient's School Grade Siblings

Reason for today's visit.

Is this your child's first visit to a dental office? ? yes ? no
If not, how would you describe your child's previous visit?

Former Dentist Date of last dental visit

Do you expect your child to be cooperative? If no please explain ? yes ? no

Does your child have any pets, hobbies, special interests or recent accomplishments?

How long is your child's attention span at home other than watching TV?

How often does your child brush?

- ? yes ? no Is tooth brushing supervised?
? yes ? no Does your child take fluoride tablets
? yes ? no Does your child take vitamins? What kind?
? yes ? no Do you have well water at home?
? yes ? no Does your child still have a night time bottle?

Does your child have or had any of the following problems or habits?

- Thumb sucking How long? Still Active ? yes ? no
Finger Habit How long? Still Active ? yes ? no
Pacifier How long? Still Active ? yes ? no

## Medical History

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Is your child presently under the care of a physician for any medical reason besides routine care? ? yes ? no If yes, what? \_\_\_\_\_

\_\_\_\_\_

Any specific health problems? ? yes ? no Please list \_\_\_\_\_

\_\_\_\_\_

Does your child have any drug allergies? ? yes ? no If yes please list. \_\_\_\_\_

\_\_\_\_\_

Is your child allergic to or had reactions to latex, red dyes, epinephrine, or others? \_\_\_\_\_

\_\_\_\_\_

Is your child taking any medications at this time? ? yes ? no If yes please list

\_\_\_\_\_

Has your child ever had a trauma to or bumped any teeth? ? yes ? no If yes please explain. \_\_\_\_\_

\_\_\_\_\_

Does your child need to be pre-medicated before any dental procedures? ? yes ? no

\_\_\_\_\_

**Responsible Party**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Father's Name                      Date of birth                      SS#

\_\_\_\_\_  
Address if different from child

\_\_\_\_\_  
Home Phone                      Cell Phone                      Business Phone

\_\_\_\_\_  
Father's employer                      Occupation

\_\_\_\_\_  
Business address

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mother's Name (Maiden Name)      Date of Birth                      SS#

\_\_\_\_\_  
Address if different from child

\_\_\_\_\_  
Home Phone                      Cell Phone                      Business Phone

\_\_\_\_\_  
Mother's employer                      Occupation

\_\_\_\_\_  
Business address

Marital Status: ? Married      ? Separated      ? Divorced      ? Widowed      ? Single

E-mail Address \_\_\_\_\_

*Who may we thank for referring your child?* \_\_\_\_\_

**In Case Of Emergency Please Notify:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                      State                      Zip

\_\_\_\_\_  
Home Phone                      Cell Phone                      Work Phone

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Neighbor                      Phone Number

