Riverway
FAMILY DENTAL

821 N Wenatchee Ave • Wenatchee WA 98801 • (509) 663-1566

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 _____

❑ **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 _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

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? _____

Form CH HH

Please see other page

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
Are you aware of grinding your teeth? ❑ 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

HEALTH HISTORY

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized during the past 2 years? ❑ Yes ❑ No
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: _____
Has your child taken any medicine / drugs during the past 2 years? ❑ 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	❑	❑	Sickle Cell Disease	❑	❑	Ulcers	❑	❑	Frequent Headaches
❑	❑	Heart Disease / Attack / Stroke	❑	❑	Blood Transfusion / Anemia	❑	❑	Emphysema / Asthma	❑	❑	Fever Blisters / Cold Sores
❑	❑	Heart Failure	❑	❑	Bruise Easily	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Fainting / Dizzy Spells
❑	❑	High / Low Blood Pressure	❑	❑	Hemophilia	❑	❑	Arthritis / Rheumatism	❑	❑	Epilepsy / Seizures
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Cortisone Medicine	❑	❑	Hay Fever / Sinus Trouble
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Kidney Failure/Dysfunction	❑	❑	Venereal Disease	❑	❑	Allergies / Hives
❑	❑	Heart Surgery	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Shingles
❑	❑	Heart Pacemaker	❑	❑	Glaucoma	❑	❑	Hepatitis: A B C **(circle one)**	❑	❑	Nervousness
❑	❑	Artificial Heart Valve	❑	❑	Chemotherapy / Cancer	❑	❑	Pain in Jaw Joint	❑	❑	Psychiatric Treatment
❑	❑	Diabetes	❑	❑	X-ray / Radiation Treatment	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Drug / Alcohol Addiction

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:

_____
_____
_____

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 Riverway Family Dental and/or dental staff to perform the necessary dental services my child my need.

Parent/Guardian Signature _____ Date ____/____/____

Medical History Update
(For Office Use Only)

Date _____ Comments _____ Date _____ Comments _____
Parent's Signature _____ Parent's Signature _____
Date _____ Comments _____ Date _____ Comments _____
Parent's Signature _____ Parent's Signature _____
Date _____ Comments _____ Date _____ Comments _____
Parent's Signature _____ Parent's Signature _____
Date _____ Comments _____ Date _____ Comments _____
Parent's Signature _____ Parent's Signature _____