EATON PEDIATRIC DENTISTRY
DR. JONATHAN EATON

Patient Information and Medical History

PATIENT NAME: _____ DATE OF BIRTH:_____ ☐ MALE ☐ FEMALE

NAME CHILD GOES BY:_____ HOME PHONE:_____

ADDRESS:_____ ZIP CODE:_____

NAMES & AGES OF OTHER CHILDREN:_____

FATHER'S NAME:_____ BUSINESS PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

MOTHER'S NAME:_____ BUSINESS PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

MARITAL STATUS OF PARENTS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ PARTNERED

PARENT'S DENTIST:_____ CHILD'S PEDIATRICIAN:_____

CHILD'S SCHOOL:_____ WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?:_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE CHECK BOX.

☐ ADD/ADHD	☐ DIABETES	☐ RESPIRATORY PROBLEM
☐ ANEMIA	☐ EPILEPSY / SEIZURES	☐ RHEUMATIC FEVER
☐ ASTHMA	☐ GASTRIC REFLUX	☐ SINUS PROBLEM
☐ AUTISM	☐ HEART DISEASE OR ARRHYTHMIA	☐ STOMACH PROBLEM
☐ BEHAVIORAL DISORDER	☐ HEART MURMUR	☐ PENICILLIN ALLERGY
☐ BLOOD DISEASE	☐ HEMOPHILIA / BLEEDING DISORDER	☐ LATEX ALLERGY
☐ BONE DISORDER	☐ KIDNEY OR LIVER DISEASE	☐ OTHER ALLERGY: _____
☐ DEVELOPMENTAL DELAY	☐ PHYSICAL DISABILITY	☐ OTHER MEDICAL CONDITION: _____

- IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN FOR OTHER THAN ROUTINE CARE? IF YES, PLEASE EXPLAIN:

_____

- PLEASE LIST ALL MEDICATIONS THAT YOUR CHILD IS TAKING AT THIS TIME:

_____

- HAS YOUR CHILD HAD AN UNFAVORABLE DENTAL EXPERIENCE? IF YES, PLEASE EXPLAIN:

_____

- DOES YOUR CHILD HAVE A HISTORY OF ☐ THUMBSUCKING, ☐ FINGERSUCKING, OR ☐ PACIFIER USE? IF YES, PLEASE CHECK BOX.

- DATE OF CHILD'S LAST DENTAL VISIT:_____

The above information is true and correct to the best of my knowledge.
I agree to inform this office immediately of any changes in my child's medical status.

_____ _____
Signature of Parent or Legal Guardian Date

Eaton Pediatric Dentistry, P.C.
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