Dr. Heather Eggenberger
Dr. Jim Cunnington
3125 Colby Ave., Suite D
Everett, WA 98201

Colby Pacific Family Dentistry

Phone (425) 259 - 4156
Fax (425) 259 - 4017
colbypacificdentistry.com

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 _____

❑ 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? _____

Please see other side

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

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 / Cobalt 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 Dr. << >> 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 _____

COLBY PACIFIC
FAMILY DENTISTRY

APPOINTMENT CANCELLATION POLICY

At Colby Pacific Family Dentistry, appointments are made by reserving the appropriate amount of time to accommodate you and your personalized treatment plan.

Our staff spends time preparing for each appointment by sterilizing, organizing, and arranging the necessary items before your arrival. This ensures that we provide the high standard of care that you want and expect.

We, therefore, require at least **48 business hours notice*** of cancellation or rescheduling. This gives us time to offer your appointed time to another patient who is waiting for an appointment. Any patient who cancels or reschedules their appointment without proper notice may be subject to a fee of $50 per hour (of appointed time) to offset some of the lost production, time, and effort the staff has already spent preparing for the appointment.

We look forward to providing your treatment in a comfortable and caring manner. Please contact our office if you have any questions or concerns.

**Our office hours are Tuesday through Friday. Notice of cancellation for Tuesday appointments may be given on Mondays to avoid charges.*

Patient printed name | Patient signature | Date