Website: www. pikeplacedental.com
Email: info@pikeplacedental.com

93 Pike Street, Suite 309 • Seattle • WA • 98101 • (206) 625-1267 • (206) 625-9017 Fax

Please answer all questions on **all** pages, 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 ______________
Social Security No. ______________ ❑ Male ❑ Female Birthdate ____/____/____

Full-Time Student? School name & location ______________________

❑ **Stepfather** ❑ **Guardian**
FATHER'S NAME ______________ Birthdate ____/____/____ Social Security No. ______________
Mailing Address ______________________ Home Phone ______________
City ______________ State ______________ Zip Code ______________
Father's Occupation ______________ Employer ______________ Work Phone ______________
Cell Phone ______________ Email ______________

❑ Married ❑ Single ❑ Partnered ❑ Other

❑ **Stepmother** ❑ **Guardian**
MOTHER'S NAME ______________ Birthdate ____/____/____ Social Security No. ______________
Mailing Address ______________________ Home Phone ______________
City ______________ State ______________ Zip Code ______________
Mother's Occupation ______________ Employer ______________ Work Phone ______________
Cell Phone ______________ Email ______________

❑ Married ❑ Single ❑ Partnered ❑ Other

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 ______________ Cell Phone ______________ Email ______________

Whom may we thank for referring you? ______________________

PIKE PLACE DENTAL

Kent deVigné, D.D.S., M.P.H.

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 been premedicated to reduce dental anxiety? ❑ 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 taken anitbiotics before dental care? ❑ Yes ❑ No

Does your child receive fluoride in vitamins, tablets, or water? ❑ Yes ❑ No

Vaccines current? ❑ 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

Physician Name ______________________

Address ______________________ Phone:__________

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
- ❑❑ Angina Pectoris
- ❑❑ Heart Disease / Attack / Stroke
- ❑❑ Mitral Valve Prolapse
- ❑❑ Heart Failure
- ❑❑ High / Low Blood Pressure
- ❑❑ Congenital Heart Defect
- ❑❑ Heart Murmur / Rheumatic Fever
- ❑❑ Heart Surgery
- ❑❑ Heart Pacemaker
- ❑❑ Artificial Heart Valve
- ❑❑ Diabetes Type:

Y N
- ❑❑ Blood Transfusion / Anemia
- ❑❑ Sickle Cell Disease
- ❑❑ Bruise Easily/Prolonged Bleeding
- ❑❑ Hemophilia
- ❑❑ Liver Disease / Yellow Jaundice
- ❑❑ Kidney Failure/Disfunction
- ❑❑ Thyroid Disease
- ❑❑ Ulcers
- ❑❑ Glaucoma
- ❑❑ Chemotherapy / Cancer
- ❑❑ X-ray / Cobalt Treatment

Y N
- ❑❑ Cosmetic Surgery
- ❑❑ Emphysema / Asthma
- ❑❑ Cough / Tuberculosis (TB)
- ❑❑ MRSA
- ❑❑ Arthritis / Rheumatism
- ❑❑ Cortisone Medicine
- ❑❑ Venereal Disease
- ❑❑ A.I.D.S. / H.I.V.
- ❑❑ Hepatitis: A B C **(circle one)**
- ❑❑ Frequent Headaches
- ❑❑ Leukemia

Y N
- ❑❑ Artificial Joints (Hip, Knee)
- ❑❑ Scarlet Fever
- ❑❑ Fever Blisters / Cold Sores
- ❑❑ Fainting / Dizzy Spells
- ❑❑ Epilepsy / Seizures
- ❑❑ Hay Fever / Sinus Trouble
- ❑❑ Allergies / Hives
- ❑❑ Shingles
- ❑❑ Nervousness
- ❑❑ Psychiatric Treatment
- ❑❑ Depression/Bipolar **(circle one)**
- ❑❑ Drug / Alcohol Addiction

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

❑ Antibiotics ❑ Aspirin ❑ Metals / Jewelry

❑ Codeine ❑ Latex ❑ 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. Kent de Vigne and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature______________________ **Date** __________

Medical History Update

(For Office Use Only)

Date________ Comments ______________________

Parent's Signature______________________

Date________ Comments ______________________

Parent's Signature______________________

Date________ Comments ______________________

Parent's Signature______________________

Date________ Comments ______________________

Parent's Signature______________________

Date________ Comments ______________________

Parent's Signature______________________

Date________ Comments ______________________

Parent's Signature______________________