BRIGHAM DENTAL CARE
Matt Ebert D.M.D.
58 BRIGHAM STREET
MORRISVILLE, VT 05661

MEDICAL AND DENTAL HISTORY

Child's Name: _____

Birth Date: _____ Age: _____

Nickname: _____ Tel: _____

Address: _____

Child's Previous Dentist: _____

Child's Physician: _____

Has your child been seen by a physician during the past 12 months? YES NO

Is your child under the care of or being treated by a physician now? YES NO

If so, for what reason? _____

Does your child have regular medical check-ups? YES NO

How often? _____

Has your child recently taken any medicine? YES NO

Please list all medicines that your child is currently taking:

_____

_____

Please list all medicines that your child is allergic to:

_____

What illnesses has your child had?
(Give age at time of illness)

Measles	_____	YES	NO
Asthma	_____	YES	NO
Mumps	_____	YES	NO
Whooping cough	_____	YES	NO
Chicken pox	_____	YES	NO
Diabetes	_____	YES	NO
Scarlet fever	_____	YES	NO
Epilepsy	_____	YES	NO
Rheumatic fever	_____	YES	NO
Polio	_____	YES	NO
Heart Disease	_____	YES	NO
Liver Disease	_____	YES	NO
Kidney Disease	_____	YES	NO
Frequent Colds	_____	YES	NO
Cerebral or mental condition	_____	YES	NO
Other	_____	YES	NO

Has your child ever bled excessively from a cut or injury? YES NO

If so, when? _____ How long? _____

Has your child ever had a tooth extracted? YES NO

Any complications? YES NO

Does your child bruise easily? YES NO

Is your child allergic to anything? YES NO

Has a dentist or physician warned you against giving this child any specific drug or medicine? YES NO

What? _____

Has this child ever had local anaesthesia (Novocaine)? YES NO

Were there any unfavorable reactions to this? YES NO

Has your child ever been a patient in a hospital overnight? YES NO

When? _____ For what reason? _____

Has your child had any operations? YES NO

When? _____

Type of Operations _____

How well does your child accept his physician? _____

Is this the first visit of your child to a dentist? YES NO

If the child has been to a dentist before, how well was treatment accepted? _____

How would you describe your child's temperment?

_____

_____

Does your child have any habits which might affect the teeth or mouth?

Breathes through mouth	YES	NO
Sucks thumb or fingers	YES	NO
Bites fingernails	YES	NO
Bites or sucks lips	YES	NO
Tongue habit	YES	NO

Other _____

How often does your child brush teeth? _____times after every meal? _____ When? _____

Has your child had fluorides of any sort? YES NO

Names and birthdays of brothers and sisters?

_____

_____

_____

Remarks: _____

_____

_____

Please Complete Information on Reverse

MOTHER'S INFORMATION

Name: _____

Address: _____

Work #_____ Home #_____

Employer: _____

Soc. Sec. #_____

Primary Dental Insurance

Ins. Co.: _____

Ins. Co. Address: _____

Insured's Name: _____

Relationship to patient: _____

Insured's birthday: _____

Soc. Sec. #: _____

Insured's Employer: _____

Payment Policy

Please be prepared to pay at the time of your visit. Whoever brings the child is responsible for payment. You may use cash, check, or credit card. We do charge a finance charge of 2% per month to all unpaid accounts. Many of our patients have some dental insurance and we will work with you to obtain your maximum benefits. Please provide us with the necessary insurance information so we may submit for you. Thank you.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need and to release information to my insurance company for payment consideration.

Signature: _____

Relationship: _____

Date: _____

FATHER'S INFORMATION

Name: _____

Address: _____

Work #_____ Home #_____

Employer: _____

Soc. Sec. #_____

Secondary Dental Insurance

Ins. Co.: _____

Ins. Co. Address: _____

Insured's Name: _____

Relationship to patient: _____

Insured's birthday: _____

Soc. Sec. #: _____

Insured's Employer: _____