Patient's Name _____ Nickname _____

Date of Birth _____ Age _____ Sex _____ Place of Birth _____

Preferred Contact # _____ Patient Lives with: Mother ☐ Father ☐ Both ☐ Other _____

Person Responsible for Account _____

Father's Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone # _____

Father's Date of Birth _____ Marital Status _____

Social Security # _____

Employer's Name _____

Employer's City _____ State _____ Zip _____

Work Phone # _____

Cell Phone # _____

Email Address _____

Mother's Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone # _____

Mother's Date of Birth _____ Marital Status _____

Social Security # _____

Employer's Name _____

Employer's City _____ State _____ Zip _____

Work Phone # _____

Cell Phone # _____

Email Address _____

Is patient covered by dental insurance? Yes ☐ No ☐

Who is insured? Mother ☐ Father ☐ Other _____

Name and Age of Siblings _____

Nearest Relative Not Living With You _____ Address _____ Phone _____

Your Child's Physician _____ Address _____ Phone _____

Your Adult Dentist _____ Address _____ Phone _____

Who Referred You to our Office? ☐ A Doctor* ☐ A Dentist* ☐ Another Family*

☐ School Talk ☐ Internet ☐ Sibling Treated Here ☐ Advertising

*Their Name & Address _____

## TELL US ABOUT OUR PATIENT

Patient's School _____

Favorite Game/Sport _____

Favorite Fictional Character _____

Any Social or School Difficulties? _____

Describe Your Child's Temperament _____

Favorite Toy _____

Favorite Hobby _____

Kind of Pet/Name of Pet _____

Learning Disabilities? _____

## HEALTH HISTORY

| | Y | N | If yes, please explain next to question. |
|---|---|---|---|
| DOES YOUR CHILD NEED TO BE PRE-MEDICATED WITH AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT? | ☐ | ☐ | _____ |
| Does your child have regular medical exams? | ☐ | ☐ | _____ |
| Is your child up-to-date with immunizations? | ☐ | ☐ | _____ |
| Is your child presently undergoing medical treatment? | ☐ | ☐ | _____ |
| IS YOUR CHILD PRESENTLY TAKING MEDICATIONS? | ☐ | ☐ | _____ |
| Has your child experienced any unfavorable reactions to medications? | ☐ | ☐ | _____ |
| IS YOUR CHILD ALLERGIC TO ANYTHING? | ☐ | ☐ | _____ |
| Has your child ever been hospitalized? | ☐ | ☐ | _____ |
| Has your child ever received any blood/blood products? | ☐ | ☐ | _____ |
| Does your child have any emotional, mental, or nervous disorders? | ☐ | ☐ | _____ |
| Is there any chance that your teenager may be pregnant? | ☐ | ☐ | _____ |

## HEALTH HISTORY

**Does your child now have or ever had any of the following?**

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ | Chicken Pox | ☐ | ☐ | Heart Disease | ☐ | ☐ | Poor Coordination |
| ☐ | ☐ | AIDS or Related Symptoms | ☐ | ☐ | Chronic Headaches | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Respiratory Disease |
| ☐ | ☐ | Anemia | ☐ | ☐ | Chronic Sinusitis | ☐ | ☐ | Hemophilia | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Convulsions/Seizures | ☐ | ☐ | Hepatitis | ☐ | ☐ | Sensory Disorder |
| ☐ | ☐ | Asthma | ☐ | ☐ | Depression | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Sickle Cell Disease or Trait |
| ☐ | ☐ | Autism | ☐ | ☐ | Diabetes | ☐ | ☐ | HIV | ☐ | ☐ | Sight Disorders |
| ☐ | ☐ | Birth Defects | ☐ | ☐ | Down Syndrome | ☐ | ☐ | Hyperactivity / ADHD | ☐ | ☐ | Spina Bifida |
| ☐ | ☐ | Bladder Disease | ☐ | ☐ | Eating Disorders | ☐ | ☐ | Kidney Disease | ☐ | ☐ | STD's |
| ☐ | ☐ | Blood Disorders | ☐ | ☐ | Epilepsy | ☐ | ☐ | Liver Disease | ☐ | ☐ | Substance Abuse |
| ☐ | ☐ | Brain Damage | ☐ | ☐ | Fainting | ☐ | ☐ | Mental Retardation | ☐ | ☐ | Thyroid Condition |
| ☐ | ☐ | Cancer/Tumors | ☐ | ☐ | Frequent Earaches | ☐ | ☐ | Mononucleosis | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Cerebral Palsy | ☐ | ☐ | Hearing Disorders | ☐ | ☐ | Mumps | ☐ | ☐ | Other _____ |

## DENTAL HISTORY

**Please answer the following questions:**

Any injuries to mouth/teeth/head?

Any mouth habits such as:

- Thumb sucking? ☐
- Finger sucking? ☐
- Nail Biting? ☐
- Nursing Bottle Habits? ☐
- Pacifier? ☐
- Lip sucking? ☐
- Tongue sucking? ☐
- Uses sippy cup? ☐

Any unusual speech habits? ☐

Does child brush teeth daily? ☐

Do you assist with tooth brushing? ☐

How often? _____

Is dental floss used? ☐

How often? _____

Are disclosing tablets used? ☐

Is fluoride taken/used in any form? ☐

What toothpaste is used? _____

1. Was your child bottle-fed? ☐
2. Is this your child's first dental visit? ☐

   If no, date of last visit and where _____
3. Has your child had an unfavorable experience in a dental office? _____
4. Do you consider your child generally high strung or nervous? _____
5. **Purpose of this appointment** _____

**Please check if your child has or had:**

- Cavities ☐
- Toothache ☐
- Teeth sensitive to sweets ☐
- Teeth sensitive to hot ☐
- Teeth sensitive to cold ☐
- Frequent mouth/lip blisters ☐
- Bleeding gums ☐
- Teeth bumped ☐
- Crooked teeth ☐
- Discoloration of teeth ☐
- Bad breath ☐
- Food packing ☐
- Mouth breathing ☐
- Snoring ☐
- Grinding of teeth ☐
- Clicking or popping of jaw ☐
- Swollen gums ☐
- Tongue/lip piercing ☐
- Other dental problems_____

*Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.*

_____

_____

As parent/legal guardian, I give my consent for Live Life Smiling Family Dentistry (LLSFD) to render dental treatment to this patient. I authorize the release of health information for reasons of treatment, payment or healthcare operations. I acknowledge the receipt of LLSFD's Notice of Privacy Practices.

In case of divorce, payment is expected from the parent/guardian who initiates treatment regardless of divorce settlement. Parents/guardians are expected to work out financials without involving LLSFD.

I agree to assign benefits to LLSFD for filed dental claims. Insurance is filed as a courtesy, and I understand the fees are my responsibility regardless of insurance coverage.

I understand that missed appointments will result in a $25 charge for each missed, and I will cancel at least 24 hours in advance if needed.

_____ _____ _____

Signature of Parent/Guardian | Relationship to Patient | Date

**Reviewed Medical History**

1_____ 2_____ 3_____ 4_____ 5_____

6_____ 7_____ 8_____ 9_____ 10_____

Live Life Smiling Family Dentistry