Little People's Dentistry

Health and Dental History

Child's History

Child's Name:_____ **Preferred Name:**_____
First Middle Last

Sex: ☐ M ☐ F Age:_____ Birthdate:_____ Place of Birth:_____

Number of Brothers? _____ Number of Sisters? _____ Is this child the: ☐ Oldest ☐ Middle ☐ Youngest

Has your child had any bad dental or medical experiences in the past? ☐ Yes ☐ No
If yes please explain:_____

Please check any of the following that may describe your child:

☐ Outgoing ☐ Regular Kid ☐ Shy ☐ Anxious ☐ Hyper ☐ Defiant ☐ Trusting
☐ Suspicious ☐ Cooperative ☐ Mellow ☐ Curious ☐ Stubborn ☐ Friendly ☐ Moody

Child's interest: _____ Favorite Sport:_____ Favorite Movie:_____

How do you expect your child to react to his/her visit today?
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Do Not Know
How can we make this visit a positive experience? _____

Whom may we thank for referring you to our office?
Who is this? ☐ Dentist ☐ Physician ☐ Teacher ☐ Relative ☐ Friend ☐ Other:_____
☐ Current Little People's Dentistry patient ☐ Former Little People's Dentistry Patient

General Information

Mother's Name:_____ Father's Name:_____

Address:_____ Address:_____

City:_____ State: _____Zip:_____ City:_____ State: _____Zip:_____

Home Phone: (_____) _____ Home Phone: (_____) _____

Work Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____) _____ Cell Phone: (_____) _____

E-mail: _____ E-mail: _____

Date of Birth: _____SSN:_____-____-_____ Date of Birth: _____SSN:_____-____-_____

Driver's License: _____ Driver's License: _____

Occupation: _____ Occupation: _____

Employer's Name: _____ Employer's Name: _____

Employer's Address: _____ Employer's Address: _____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

Work Phone: (_____)_____ Work Phone: (_____)_____

Who does the child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____
Who is the child's legal guardian? ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____
Name of person responsible for this account:_____

IN CASE OF EMERGENCY, who should we contact? (Please specify someone not living in your household)
Name:_____ Relationship: _____
Home Phone:_____ Work Phone: _____

Child's Name:_____

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Dental History

Reason for Today's Visit:_____

☐ Yes ☐ No Is this your child's first dental visit?

Name of former dentist: _____ Phone: _____ ☐ General ☐ Pediatric

☐ Yes ☐ No Does your child brush daily?
☐ Yes ☐ No Does and adult assist with brushing?
☐ Yes ☐ No Does your child floss?
☐ Yes ☐ No Does an adult assist with flossing?

Does your child have any of the following mouth habits?

☐ Finger Sucking ☐ Thumb Sucking ☐ Lip Sucking ☐ Tongue Thrusting
☐ Mouth Breathing ☐ Teeth grinding ☐ Nail Biting ☐ Pacifier ☐ Other:_____

Does your child receive fluoride in any of the following forms?

☐ In Vitamins ☐ Water ☐ Toothpaste ☐ Tablets/ Drops ☐ Rinse/ Gel ☐ Other:_____

Medical History

☐ Yes ☐ No Is your child in good health?
☐ Yes ☐ No Does your child need to be pre-medicated before dental treatment?
☐ Yes ☐ No Is your child being treated for any condition presently?
If so, please explain:_____
☐ Yes ☐ No Has your child ever been hospitalized or had any surgeries?
If so, for what:_____
☐ Yes ☐ No Does your child have any allergies/ medications?
If so, to what? _____
☐ Yes ☐ No Is your child taking any medications?
If so, please explain:_____

Has your child ever been diagnosed as having any of the following conditions?

☐ Yes	☐ No	AIDS	☐ Yes	☐ No	Convulsion seizures	☐ Yes	☐ No	Heart problems
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Developmental delay	☐ Yes	☐ No	Hemophilia
☐ Yes	☐ No	ADHD	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Kidney/ Liver
☐ Yes	☐ No	Asthma						Problems
☐ Yes	☐ No	Autism	☐ Yes	☐ No	Ear infections	☐ Yes	☐ No	Leukemia
☐ Yes	☐ No	Blood transfusion	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Nutrition Deficiency
☐ Yes	☐ No	Bone / joint problems	☐ Yes	☐ No	Eye problems	☐ Yes	☐ No	Oral Ulcers
☐ Yes	☐ No	Brain Injury	☐ Yes	☐ No	Excessive gagging	☐ Yes	☐ No	Orthopedic problems
☐ Yes	☐ No	Bruise easily	☐ Yes	☐ No	Emotional Disturbances	☐ Yes	☐ No	Rheumatic Fever
☐ Yes	☐ No	Cancer/Malignancies	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Sickle Cell Anemia
☐ Yes	☐ No	Chronic headaches	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Spinal Bifida
☐ Yes	☐ No	Cerebral Palsy	☐ Yes	☐ No	Hearing/Speech problems	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Child/Sexual Abuse	☐ Yes	☐ No	Hyperactivity	☐ Yes	☐ No	Tonsil problems
☐ Yes	☐ No	Syndrome:_____						

Please describe any current medical treatment including drugs. pending surgery, recent injuries, hospitalizations or any other information we should be aware of that has not been covered: _____

_____

I CERTIFY THE ABOVE IS COMPLETE AND ACCURATE

Date:_____ Signature of Legal Guardian:_____

Print Name of Legal Guardian:_____