info@LiveSmileLaugh.com
LiveSmileLaugh.com
1110 W. Robinhood Dr. / Stockton, CA 95207

209.478.4666

CHILD PATIENT FORM

Date ____________________

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Patient's Name ____________________ FIRST ____________________ MIDDLE ____________________ LAST

Nickname ____________________

Address ____________________ STREET ____________________ APT #

____________________ CITY ____________________ STATE ____________________ ZIP

Home Phone ____________________ Cell Phone ____________________

Email ____________________ Birthdate ____________________ Age ________ Female ☐ Male ☐

Patient's Family Dentist ____________________

Patient's Family Physician ____________________

Referred By ____________________

School Currently Attending ____________________

Parent's Name ____________________	Parent's Name ____________________
Address *(if different from patient)*	Address *(if different from patient)*
____________________ STREET ________ APT #	____________________ STREET ________ APT #
____________________ CITY ________ STATE ________ ZIP	____________________ CITY ________ STATE ________ ZIP
Employer ____________________	Employer ____________________
Occupation ____________________	Occupation ____________________
Social Security No. ____________________	Social Security No. ____________________
Work Phone ____________________	Work Phone ____________________
Insurance Company ____________________	Insurance Company ____________________
Group No. ____________________	Group No. ____________________
Birthdate ____________________	Birthdate ____________________

Emergency Contact ____________________ Phone ____________________

Has a family member ever been a patient in this office? ______ If yes, whom? ____________________

PLEASE COMPLETE THE BACK

FOR OFFICE USE ONLY

____________________ AGE ____________________ MAX ____________________ %

MEDICAL HISTORY

Is the patient presently under a physician's care? ☐ Yes ☐ No

Is the patient taking any pills, medications, or drugs? ☐ Yes ☐ No

Is the patient allergic to any kind of medications or foods? ☐ Yes ☐ No

Please List ____________________

Has the patient ever had any unusual reaction to any medications? ☐ Yes ☐ No

Has the patient ever had major surgery? ☐ Yes ☐ No

Procedure ____________________ Date ____________

Has the patient had tonsils removed? ☐ Yes ☐ No

Has the patient had adenoids removed? ☐ Yes ☐ No

Does the patient have any health problems with:

Heart ☐ Yes ☐ No   Lungs ☐ Yes ☐ No   Kidneys ☐ Yes ☐ No   Liver ☐ Yes ☐ No

Has the patient ever been diagnosed or treated for any of the following?:

Asthma ☐ Yes ☐ No	Headaches ☐ Yes ☐ No	Cerebral Palsy. ☐ Yes ☐ No
AIDS ☐ Yes ☐ No	Prolonged bleeding ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No
Earaches ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No
Fainting ☐ Yes ☐ No	Anemia ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No

Are there ANY other medical conditions not mentioned above?

____

____

DENTAL HISTORY

Date of patient's last Dental Appointment ____________

Does the patient breathe mostly through the mouth? ☐ Yes ☐ No

Does the patient clench or grind teeth? ☐ Yes ☐ No

Does the patient have pain or clicking of the jaw when opening mouth? ☐ Yes ☐ No

Does the patient have any teeth that have been injured or chipped? ☐ Yes ☐ No

Does the patient have difficulty in chewing or swallowing food? ☐ Yes ☐ No

Does the patient have any missing or extra teeth? ☐ Yes ☐ No

Has the patient ever had orthodontic treatment before? ☐ Yes ☐ No

Has the patient ever worn a retainer or space maintainer before? ☐ Yes ☐ No

Has any member of the patient's family had orthodontic treatment? ☐ Yes ☐ No

---

SIGNATURE OF RESPONSIBLE PARTY ____________________ **DATE** ____________

SIGNATURE OF DENTIST ____________________ **DATE** ____________