Welcome to Dr. Luffey's Office!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help your child maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for her/him!

About Your Child

Name: ______________________________________ Child prefers to be called: ___________________
Last First Middle
□Female □Male Birth date: ___________________
Mother: _______________________________ Father: _________________________________
Home Address____
Mailing Address: ____
Home Phone #: __________________
Mom's Cell #: __________________________ Mom's Work #: _________________________
Dad's Cell #: __________________________ Dad's Work #: _________________________
Other adults who may bring child for treatment? ____
What is the BEST way for us to confirm your child's appointments? ______________________________

Emergency Contact Information

Name: ____ Relationship: ____________________
Contact phone # ____________________________ Alternate contact #: ________________

Dental History

What is your reason for your child's dental appointment? ____________________________________
Are they currently in pain? □ Yes □ No
Do they floss daily? □ Yes □ No How many times/day are their teeth brushed? □ 0 □ 1 □ 2 □ 3+
What type of toothbrush do they use? □ Manual □ Battery □ Electric
Do their gums ever bleed? □ Yes □ No Do their gums ever itch or tingle? □ Yes □ No
Do they have any loose teeth? □ Yes □ No Where? _______________________________________
Are their teeth sensitive to hot, cold, pressure or sweets? ______________________________________
Have they ever had any serious complications with prior dental treatment? ? □ Yes □ No
If yes, what? ____
Have they had any orthodontic work? □ Yes □ No If yes, please describe:
____
Have they ever been in a car accident? □ Yes □ No
Are they fearful of dental procedures, needles or do you experience dental anxiety? □ Yes □ No
Other ____

Has your child experienced any of the following problems in their head, neck or jaw?

Clenching of teeth?	□ Yes □ No	Face pain?	□ Yes □ No	Neck injury?	□ Yes □ No
Teeth grinding?	□ Yes □ No	Head injury?	□ Yes □ No	Pain (jaw, joint, ear, side of face)?	□ Yes □ No
Clicking in jaw?	□ Yes □ No	Headaches?	□ Yes □ No		
Difficulty in chewing?	□ Yes □ No	Jaw pain or injury?	□ Yes □ No	Ringing in the ears?	□ Yes □ No
Difficulty swallowing?	□ Yes □ No	Limited opening of mouth?	□ Yes □ No	Sleep problems?	□ Yes □ No
Difficulty opening or closing?	□ Yes □ No			Does your child snore?	□ Yes □ No

Medical History

Do you they have a personal physician? □ Yes □ No Physician's Name: ________________________
Phone #: ____________________________ Date of last visit? _______________________________
Their current physical health is: □ Excellent □ Good □ Fair □ Poor
Are they required to pre-medicate before a dental visit? □ Yes □ No Reason? ___________________
Are they currently under the care of a physician? □ Yes □ No If yes, please explain: ______________
Please list any medications, vitamins, herbs, etc., that they are taking. ___________________________
____
Do they have abnormal blood pressure? □ Yes □ No □ Unsure If yes, what is it usually? ____ s/ ____d
Has your child had their tonsils and adenoids removed? □ Yes □ No
Has speech therapy been recommended for your child? □ Yes □ No
Has your child experienced growth problems? □ Yes □ No
Does your child suck their thumb/finger? □ Yes □ No Bite their nails? □ Yes □ No
Bite their cheek? □ Yes □ No

Has your child experienced the following?

Abnormal bleeding	□ Yes □ No	Fainting spells	□ Yes □ No	Radiation treatment	□ Yes □ No
ADD	□ Yes □ No	Fever blisters	□ Yes □ No	Recurrent illnesses	□ Yes □ No
ADHD	□ Yes □ No	Hay fever	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Anemia	□ Yes □ No	Herpes	□ Yes □ No	Scarlet fever	□ Yes □ No
Arthritis	□ Yes □ No	Heart (surgery, artifi-		Seizures	□ Yes □ No
Asthma	□ Yes □ No	cial valve, murmur)	□ Yes □ N	Sinus problems	□ Yes □ No
Blood Disorder	□ Yes □ No	Hepatitis □ A □ B	□ C □ No	Slow healing mouth	
Cancer	□ Yes □ No	HIV infection/AIDS	□ Yes □ No	sores	□ Yes □ No
Chemo therapy	□ Yes □ No	Infections	□ Yes □ No	Steroid therapy	□ Yes □ No
Circulatory problems	□ Yes □ No	Kidney problems	□ Yes □ No	Thyroid problems	□ Yes □ No
Diabetes	□ Yes □ No	Liver disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Difficulty breathing	□ Yes □ No	Lupus	□ Yes □ No	Tuberculosis	□ Yes □ No
Respiratory problems	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Unintentional	
Epilepsy	□ Yes □ No	Persistent cough	□ Yes □ No	weight gain/loss	□ Yes □ No
Ever hospitalized	□ Yes □ No	Psychiatric care	□ Yes □ No	Venereal Disease	□ Yes □ No

Is your allergic to any of the following?

Aspirin	□ Yes □ No	Erythromycin	□ Yes □ No	Latex	□ Yes □ No	Sedatives	□ Yes □ No
Codeine	□ Yes □ No	Jewelry/Metals	□ Yes □ No	Penicillin	□ Yes □ No	Sulfa drugs	□ Yes □ No

Does your child have any food allergies? □ Yes □ No If yes, please list: ________________________________
____

Authorization

I affirm that the information I have given is to the best of my knowledge. It is my responsibility to inform this office of any changes in address, insurance or medical status. I understand that I am responsible for payment of services rendered. As a courtesy, the office will file most insurances. I have received this office's Notice of Privacy Practices.

____ ____________________
Signature Date