



# PEDIATRIC DENTISTRY

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**This record is confidential and for use only in this office.**

The following information and history are necessary for the adequate treatment and understanding of your child.  
*Thank you for completing it in full.*

## I. SOCIAL HISTORY

Patient's Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Patient's Social Security# \_\_\_\_\_

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

- |                                     |                                |                                      |                                      |                                     |                                      |
|-------------------------------------|--------------------------------|--------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Outgoing   | <input type="checkbox"/> Shy   | <input type="checkbox"/> Stubborn    | <input type="checkbox"/> Anxious     | <input type="checkbox"/> Frightened | <input type="checkbox"/> Defiant     |
| <input type="checkbox"/> Suspicious | <input type="checkbox"/> Moody | <input type="checkbox"/> High Strung | <input type="checkbox"/> Regular Kid | <input type="checkbox"/> Friendly   | <input type="checkbox"/> Cooperative |

Name & type of child's pet \_\_\_\_\_ Favorite Interest \_\_\_\_\_ Favorite Sport \_\_\_\_\_

How do you expect your child to react to his/her visit today?  Excellent  Good  Fair  Poor  Not Sure

Child lives with:  Both parents  Mother  Stepmother  Father  Stepfather  Grandparent  Other

Patient's Address \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

His Address \_\_\_\_\_ Phone# \_\_\_\_\_

Where Employed \_\_\_\_\_ Phone# \_\_\_\_\_

Mother's Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Her Address \_\_\_\_\_ Phone# \_\_\_\_\_

Where Employed \_\_\_\_\_ Phone# \_\_\_\_\_

Phone Number for Confirmation of Appointment \_\_\_\_\_ Email Address: \_\_\_\_\_

Other children in the family-names and ages \_\_\_\_\_

Whom may we thank for referring you to our office? Doctor \_\_\_\_\_ Parent \_\_\_\_\_ Patient \_\_\_\_\_

Has this office rendered treatment to any other family members? Names \_\_\_\_\_

Reason for bringing child to dentist \_\_\_\_\_

## II. MEDICAL HISTORY

Condition of the child's general health \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

How long since your child's last physical examination? \_\_\_\_\_ How long since his/her last tetanus shot? \_\_\_\_\_

Child's physician \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

Yes  No Are your child's immunizations up to date? \_\_\_\_\_

Yes  No Does your child have physical or mental disabilities? If yes, explain \_\_\_\_\_

Yes  No Has your child ever been hospitalized or had an operation? \_\_\_\_\_ Date \_\_\_\_\_  
Reason \_\_\_\_\_ Doctor \_\_\_\_\_ Where \_\_\_\_\_

Yes  No Has your child ever had a blood transfusion? Date \_\_\_\_\_ Reason \_\_\_\_\_

Yes  No Has your child received medical treatment within the last six months? If yes, explain \_\_\_\_\_

Yes  No Has your child ever had hearing, sight, speech, or learning problems? If yes, explain \_\_\_\_\_

Yes  No Is your child currently receiving speech therapy? If yes, by whom? \_\_\_\_\_

Yes  No Has your child ever received injuries to the head, jaw, mouth, or teeth? If yes, describe \_\_\_\_\_

Yes  No Is your child allergic to any medication or food? If yes, what? \_\_\_\_\_

Yes  No Is your child taking any medicine now? If yes, what? \_\_\_\_\_

Preferred Pharmacy & Number \_\_\_\_\_

**ILLNESS**

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no.

|                          |                          |                                   |                          |                          |                            |                          |                          |                         |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-------------------------|
| Yes                      | No                       |                                   | Yes                      | No                       |                            | Yes                      | No                       |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS (Immunosuppressive Disorder) | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems               | <input type="checkbox"/> | <input type="checkbox"/> | Polio                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                            | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant                |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy                           | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                   | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorder    |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                         | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss               | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever           |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                            | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease              | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism                            | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                 | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia      |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury                      | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis - Type_____      | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems          |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis                        | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                   | <input type="checkbox"/> | <input type="checkbox"/> | Snoring at Night        |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                            | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia                   | <input type="checkbox"/> | <input type="checkbox"/> | Sore Throats - frequent |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy                    | <input type="checkbox"/> | <input type="checkbox"/> | Measles                    | <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida            |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox                       | <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation         | <input type="checkbox"/> | <input type="checkbox"/> | Syndrome_____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip/Palate                  | <input type="checkbox"/> | <input type="checkbox"/> | Mumps                      | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Seizures              | <input type="checkbox"/> | <input type="checkbox"/> | Mouth Breathing            | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                          | <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency     | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease        |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria                        | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems        | <input type="checkbox"/> | <input type="checkbox"/> | Whooping Cough          |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Abuse             | <input type="checkbox"/> | <input type="checkbox"/> | Past Pregnancy             | <input type="checkbox"/> | <input type="checkbox"/> | Other_____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                          | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                  |                          |                          |                         |

This child has never been diagnosed as having any of the above conditions.

**III. DENTAL HISTORY**

Yes  No Is this your child's first trip to the dentist? If no, name of previous dentist\_\_\_\_\_

Approximate date of last visit\_\_\_\_\_

Yes  No Has your child experienced any unfavorable reactions from previous dental or medical care?

If yes, explain\_\_\_\_\_

Approximate date of last visit\_\_\_\_\_

Yes  No Has your child had a toothache recently?

Yes  No Has your child received any trauma to his/her teeth?

Yes  No Does your child have a history of mouthbreathing, thumbsucking, fingersucking, pacifier dependency, lip/nail biting or other habits? (if yes, circle)

How was your child fed as an infant?  Breast  Bottle

When did you stop breast or bottle feeding? Age\_\_\_\_\_

Yes  No Is your child taking any vitamins or flouride?

What toothpaste does your child use?\_\_\_\_\_

What is your water source?  Private well  City Water Name of City\_\_\_\_\_

What source water do you drink?  Tapped  Bottled

How often are your child's teeth brushed per day? \_\_\_\_\_ By whom?\_\_\_\_\_

Yes  No Does your child have a dental condition about which you are especially concerned? If yes, explain\_\_\_\_\_

\_\_\_\_\_

Yes  No Does your child consume large amounts of sugar? If yes, source\_\_\_\_\_

Yes  No Does your child gag easily?

Yes  No Is there anything else about your child that you think I should know in order to better plan his/her dental treatment?

**IV. CONSENT**

I acknowledge that the above mentioned information is correct, and I authorize Dr. Skip Tyson and/or Dr. Stephanie Heaney and staff to provide dental and related medical/surgical treatment as deemed necessary utilizing proper and acceptable methods to complete same, including diagnostic radiographs and photographs.

Parent or Legal Guardian\_\_\_\_\_ Date\_\_\_\_\_