Wilmington Pediatric Dentistry

Skip Tyson, D.D.S.

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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:

☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Defiant

☐ Suspicious ☐ Moody ☐ High Strung ☐ Regular Kid ☐ Friendly ☐ 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___________

Mother/Father's Full Name__________________ Social Security #__________ Date of Birth________

Her/His Address__________________________________ Phone #____________

Where Employed__________________________________ Phone #____________

Mother/Father's Full Name__________________ Social Security #__________ Date of Birth________

Her/His 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 and/or intellectual 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	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	AIDS (Immunosuppressive Disorder)	☐	☐	Eye Problems	☐	☐	Pneumonia
☐	☐	Anemia	☐	☐	Excessive Bleeding Problem	☐	☐	Polio
☐	☐	Allergy	☐	☐	Fainting	☐	☐	Pregnant
☐	☐	Arthritis	☐	☐	Hearing Loss	☐	☐	Psychiatric Disorder
☐	☐	Asthma	☐	☐	Heart Defect – Type ________	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Heart Disease	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	Hepatitis – Type ________	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats - frequent
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Spina Bifida
☐	☐	Cleft Lip/Palate	☐	☐	Intellectual Disability	☐	☐	Syndrome ______
☐	☐	Convulsions/Seizures	☐	☐	Mumps	☐	☐	Tetanus
☐	☐	Diabetes	☐	☐	Mouth Breathing	☐	☐	Tuberculosis
☐	☐	Diphtheria	☐	☐	Nutritional Deficiency	☐	☐	Whooping Cough
☐	☐	Drug or Alcohol Abuse	☐	☐	Orthopedic Problems	☐	☐	Other_________________
☐	☐	Epilepsy	☐	☐	Past Pregnancy			________________

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

III. DENTAL HISTORY

☐ Yes ☐ No Is this your child's first visit 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 received any trauma to his/her teeth?

☐ Yes ☐ No Does your child have a history of mouth breathing, thumb sucking, finger sucking, pacifier dependency lip/nail biting or other habit? (if yes, circle which ones)
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 fluoride?
What toothpaste does your child use? _____________________
What is your water source? ☐ Private Well ☐ City Water ☐ Name of City_________________________
What source of 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? ____
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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**_______________________