MIDLANDS
pediatric dentistry
ROBERT SHOUN, DMD

# Social and Health History Form

Today's Date: _____/_____/_____

## Social History

### Child

Child's Name: Last_____First_____ MI _____ Preferred Name: _____
Date of Birth: ____/____/____ ☐ Male ☐ Female Home Phone #: _____ SSN: _____
Home Address: _____
Siblings we treat: _____
School: _____ Grade: _____ Progressing normally: ☐ Yes ☐ No
Does your child have any behavioral or learning problems? ☐ Yes ☐ No If yes, explain: _____
Has your child had testing in the areas of: hearing, vision, speech, motor, behavior, or development? (Please circle)
Is your child receiving or has your child received speech therapy, occupational therapy, or physical therapy? (Please circle)
Does your child separate from you willingly? ☐ Never/Rarely ☐ Sometimes ☐ Most of the time ☐ Always
Does your child have tantrums? ☐ Never/Rarely ☐ Sometimes ☐ Frequently
Hobbies: _____
Pets and Names: _____
List anything else you would like to share about your child to assist us in providing care: _____
_____

### Parent/Legal Guardian

Parent's Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single
Name: _____ ☐ Mother ☐ Father ☐ Step ☐ Guardian ☐ Foster
Date of Birth: _____/_____/_____ Employer: _____ Occupation: _____
Address: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
Email: _____

Name: _____ ☐ Mother ☐ Father ☐ Step ☐ Guardian ☐ Foster
Date of Birth: _____/_____/_____ Employer: _____ Occupation: _____
Address: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
Email: _____

### Person Responsible for Account (refers to person who fills out paperwork, makes appointments, and responsible for any charges)

Name: _____ Relationship: _____ SSN: _____
Billing Address: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone#: _____
Driver's License # and State: _____ Employer: _____

### Primary Dental Insurance

Insurance Company Name: _____ Policy #: _____ Group#: _____
Address: _____ Phone#: _____
Policy Owner's Name: _____Relationship: _____Policy Owner's DOB: _____/_____/_____
Policy Owner's SSN: _____ Policy Owner's Employer: _____

### Secondary Dental Insurance

Insurance Company Name: _____ Policy #: _____ Group#: _____
Address: _____ Phone#: _____
Policy Owner's Name: _____Relationship: _____Policy Owner's DOB: _____/_____/_____
Policy Owner's SSN: _____ Policy Owner's Employer: _____

Child's Name: Last_____First_____MI_____ Date of Birth:____/____/____

## Health History

### Medical History

Child's Physician: _____ Physician's Office: _____

Physician's Address: _____Physician's Phone#: _____

Are immunizations current? ☐ Yes ☐ No Your Child's current physical condition: ☐ Good ☐ Fair ☐ Poor

Current medications: _____

Allergies: _____

Hospitalizations: _____

Has your child had or experienced any of the following: (Please circle)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y N | Abnormal Bleeding | Y N | Bone Disorder | Y N | Hepatitis | Y N | Rheumatic Fever |
| Y N | ADD/ADHD | Y N | Cancer | Y N | Kidney Disorder | Y N | Scarlet Fever |
| Y N | AIDS/ HIV | Y N | Congenital Heart Defect | Y N | Liver Disorder | Y N | Seizure Disorder |
| Y N | Anemia | Y N | Diabetes | Y N | Lung Disease | Y N | Sickle Cell Anemia |
| Y N | Asthma | Y N | Endocrine Disorder | Y N | Malignant Hyperthermia | Y N | Sleep Apnea |
| Y N | Autism/Related disorder | Y N | Eye Disorder | Y N | Mental Disabilities | Y N | Snoring |
| Y N | Blood Disorder | Y N | Hearing Impairment | Y N | Mitral Valve Prolapse | Y N | Stomach/GI Disorder |
| Y N | Blood Pressure high/low | Y N | Heart Murmur | Y N | Muscle Disorder | Y N | Tonsillitis |
| Y N | Blood Transfusion | Y N | Hemophilia | Y N | Nose/Throat Disorder | Y N | Tuberculosis |

Please list any medical problems not listed above: _____

### Dental History

Is this your child's first dental visit? ☐ Yes ☐ No If No, where has your child been seen before: _____

Primary reason for visit: _____

Has your child ever experienced any problems with dental work? ☐ Yes ☐ No _____

Is your child currently in pain? ☐ Yes ☐ No _____

Has your child ever had any trauma to his/her teeth, mouth, or head? ☐ Yes ☐ No _____

Is your water fluoridated? ☐ Yes ☐ No Does your child use any fluoride supplements? ☐ Yes ☐ No

Does your child brush his/her own teeth? ☐ Yes ☐ No Does an adult assist with brushing? ☐ Yes ☐ No

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

What things are you most concerned about for today's visit?_____

_____

Does/Did your child have any of the following habits: (Please circle)

| | | | | | |
|---|---|---|---|---|---|
| Y N | Bottle habit until age_____ | Y N | Lip Sucking/Biting | Y N | Sippy Cup |
| Y N | Breast Fed until age_____ | Y N | Mouth Breathing | Y N | Thumb/Finger Sucking until age___ |
| Y N | Chewing on objects | Y N | Nail Biting | Y N | Tongue/Cheek Biting |
| Y N | Clenching/Grinding Teeth | Y N | Pacifier until age____ | Y N | Tongue Thrust |

Whom may we thank for referring you to us: _____

I confirm that the above information I have given is correct and true to the best of my knowledge. I understand that providing incorrect information can be harmful to my child's health. I also understand it is my responsibility to inform the office of any changes in my child's medical status. I authorized Dr. Robert Shoun and his staff to provide dental treatment, which may include cleanings, fillings, x-rays, examinations, fluoride treatments, local anesthetic and nitrous oxide. I understand that payment is expected as services are rendered.

_____ _____

Signature of parent or legal Guardian Date