

Greenwich Pediatric Dental Group, L.L.C.

Stacy Zarakiotis, D.D.S

Date _____

Child's Name _____ M / F Nickname _____

Date of Birth _____ School _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

PARENT INFORMATION

Father's full name _____ Occupation _____ S.S# _____

Employed by _____

Business address _____

Telephone _____ Cell _____ Email _____

Mother's full name _____ Occupation _____ S.S# _____

Employed by _____

Business address _____

Telephone _____ Cell _____ Email _____

Are you: Married Single Separated Widowed Divorced

Who is responsible for this account? _____

Address of this person: _____

CHILD'S HEALTH HISTORY

Reason for dental visit _____

Family dentist _____

Child's previous dentist _____

Date of last dental visit _____ Date of last dental X-rays _____

Has there ever been a problem with previous dental care? _____

If so, please explain _____

Have your child's teeth been injured in an accident? _____

Does your home have city water supply or well water? _____

Does your child take fluoride supplements? _____

Does your child have a habit, such as thumb sucking, use of a pacifier or nail biting, that may effect his teeth?

Do you nurse your child to sleep or does your child take a bottle to sleep? _____

Do you help brush your child's teeth? _____

Name of your child's physician _____ Telephone _____

Your child's health is: Excellent Fair Poor

Is your child taking medication at the present time? If so, what type of medication? _____

Is your child taking vitamins at the present time? If so, what type of vitamins? _____

Does your child have any or history of the following:

| | | | | | |
|---------------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Congenital birth defects | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyesight problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney or liver problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Speech problems or impairments | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aids/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy seizure disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Handicap or emotional problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Any other pertinent medical information or any unusual conditions? _____

Has your child ever been hospitalized or undergone surgery? If so, please explain _____

Is your child allergic to penicillin, antibiotics or other medicine? _____

If so, please explain _____

Is your child allergic to or sensitive to any metals or latex? If so, please explain _____

Has your child experience severe or prolonged bleeding? If so, please explain _____

CHILD'S TEMPERAMENT

Shy Fearful Requires special understanding Easygoing Calm Outgoing Manipulative

How do you think your child will act during dental treatment? _____

Is there anything else you would like us to know about your child? _____

How has your child's experience been with other doctors? _____

OTHER INFORMATION

Names and ages of brothers and sisters: _____

Hobbies, pets, favorite TV shows, etc. _____

Is there someone we should thank for referring your child? _____

Where / Whom may we call regarding your appointment? _____

To the best of my knowledge the information provided is accurate and complete and if there is a change in my child's health or medications, I will inform the doctor. THE PARENT/GUARDIAN WHOSE SIGNATURE APPEARS BELOW CONSENTS TO TREATMENT AS EXPLAINED TO THEM BY DR. ZARAKIOTIS OR OTHER DENTAL PROFESSIONALS AND IS RESPONSIBLE FOR ALL FEES AT THE TIME SERVICES ARE RENDERED.

Signature _____ Relationship _____