Greenwich Pediatric Dental Group, L.L.C.

Stacy Zarakiotis, D.D.S. ♦ Emily Gabeler, D.D.S.

Date_____

CHILD INFORMATION

Child's Name_____ ❑ M / ❑ F Nickname _____

Date of Birth _____School _____ Home Phone _____

Address _____City _____ State _____ Zip _____

PARENT INFORMATION

Parent 1 Full name_____ DOB _____/_____/ _____

Email _____

Parent 2 Full name_____ DOB _____/_____/ _____

Email _____

Who is responsible for this account? _____

Address of this person: _____

CHILD'S HEALTH HISTORY

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	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Heart problems	❑ Yes	❑ No	Congenial birth defects	❑ Yes	❑ No
Rheumatic fever	❑ Yes	❑ No	Eyesight problems	❑ Yes	❑ No
Kidney or liver problems	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Allergies	❑ Yes	❑ No	Infections	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Speech problems or impairments	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hearing loss	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Aids/HIV	❑ Yes	❑ No
Bleeding problems	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No
Epilepsy seizure disorder	❑ Yes	❑ No	Handicap or emotional problem	❑ Yes	❑ 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 prolongated bleeding? If so, please explain _____

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 _____