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

Parent 1 Full name________________ Occupation ______________ S.S.# ________

Employed by ____________________________________ DOB ___/___/ _____

Business address ____

Telephone________________ Cell ______________ Email______________

Parent 2 Full name________________ Occupation ______________ S.S.# ________

Employed by ____________________________________ DOB ___/___/ _____

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:

Condition	Yes	No	Condition	Yes	No
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 ________________

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.

PLEASE NOTE: Any cancellations within 24 hrs. of patient scheduled appointment may be subject to a $50 cancellation fee.

Signature____________________ Relationship ____________________