

Elizabeth Kitsos, DDS
Practice Limited to Dentistry for Children and Adolescents
111 Broadway – Suite 1701
New York, NY 10006
212-267-0029

Date _____

PERSONAL HISTORY

Child's Name _____ Referred _____

Address _____ Phone _____

Father's Name & Address _____

Father's Occupation & Business Address _____

Father's Business Phone _____ Father's Social Security Number _____

Mother's Name & Address _____

Mother's Occupation & Business Address _____

Mother's Business Phone _____ Mother's Social Security Number _____

Child's Age _____ Birth Date _____ Nickname _____

Names & Ages of Brothers & Sisters _____

Hobbies, Pets, Favorite T.V. Shows, etc, _____

Person Responsible For This Account _____

DENTAL HISTORY

Reason for this visit (1st examination, check-up, toothache, etc.) _____

How long since last visit to a dentist? _____

Was the dental experience pleasant or unpleasant? _____

If unpleasant, how did he/she react? _____

Did he/she object to anything in particular? _____

Has your child have any history of thumb or lip sucking, pacifier, nail or lip biting (if yes, Please explain) _____

Was you child ever given fluoride supplements or vitamins with fluoride? _____

MEDICAL HISTORY

Name of Family Physician or Pediatrician _____ City _____ Phone _____

Is your child in good health? _____ Is your child taking any medications? _____

Which medications does your child have allergies to? _____ General allergies? _____

Does your child have a history of diabetes, asthma, kidney or liver problem? _____

Does your child a history of bleeding or anemia? _____

Has your child ever had Rheumatic Fever, Heart Trouble or Heart Murmur? _____

Has your child ever been admitted to a hospital? _____ (If yes, please explain _____

Has your child ever had a transfusion? _____

Does your child have a handicap or perceptual problem? _____ (if yes, please explain _____

Any additional medical or related problem? _____

Signature _____

Relationship _____