Dr. Elizabeth Kitsos
Pediatric Dentistry

PATIENT INFORMATION

Child's Name _____ Date _____

Home Address _____ Phone _____

Sex ☐M ☐F Age _____ Birth Date _____ Nickname _____

Names and Ages of Brothers and Sisters _____

Hobbies, Pets, Favorite TV Shows, etc. _____

Person Responsible for this Account _____ Email _____

Whom may we thank for referring you? _____

DENTAL HISTORY

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

Has your child ever had an injury to the mouth, teeth or jaws (fall, blow, 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? _____

Does your child have any history of thumb or lip sucking, pacifier, nail or lip biting? If yes, please explain _____

Does your child use fluoride toothpaste? _____

Has your child ever taken fluoride supplements or vitamins with fluoride? _____

MEDICAL HISTORY

Child's physician/pediatrician _____ City _____ Phone _____

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

Is your child allergic to any medicines? _____ General allergies? _____

Any history of cerebral palsy, seizures, fainting, or loss of consciousness?	No ☐	Yes ☐
Any sensory disorders? (seeing, hearing, Sensory Integration Disorder)	No ☐	Yes ☐
Has your child been diagnosed with PDD, autism, ADHD or ADD?	No ☐	Yes ☐
Any history of congenial heart disease, heart murmur or rheumatic fever?	No ☐	Yes ☐
Has any heart surgery been done or recommended?	No ☐	Yes ☐
Has your child ever had a blood transfusion?	No ☐	Yes ☐
Any history of anemia or sickle cell disease?	No ☐	Yes ☐
Does your child bruise easily or bleed excessively from small cuts?	No ☐	Yes ☐
Any history of pneumonia, cystic fibrosis, asthma, or difficulty breathing?	No ☐	Yes ☐