LISA RITTER-KAHN, D.M.D.
DOUGLAS S. SCHILDHAUS, D.M.D.
CELIA SPATT PENZER, D.M.D.
Pediatric Dentistry

HARRY J. TSOTSOS, D.M.D.
ALEXANDRIA ANAGNOSTIS, D.M.D.
Orthodontics

Infants • Children • Young Adults
800 Woodbury Road, Woodbury,, New York 11797
(516) 921-0400

CHILD'S HISTORY & INFORMATION

(Please print clearly)

Child's Name ______________________ Nickname __________ Age _____ Birth Date _____
LAST NAME FIRST NAME

Home Address/Town ______________________________ Phone ______________

School Attending ____________________ Referred By ______________________

Child's Physician & Phone ______________________________

	Father	Mother
Parent's Name		
Date of Birth		
Social Security Number		
Occupation		

Business Address (PARENT) ______________________________ Phone ______________

Insurance Carrier ______________________ Cell Phone ______________

E-Mail ______________________

Have any of your children been seen in this office ❑ yes ❑ no

Please list their names ______________________________

DOES YOUR CHILD HAVE OR HAS HE/SHE EVER HAD (Please circle)

1. Heart murmur/problem	yes	no	8. Allergies	yes	no
2. Rheumatic fever	yes	no	9. Diabetes	yes	no
3. Mental illness	yes	no	10. Tuberculosis	yes	no
4. Nervous disorder	yes	no	11. Convulsions	yes	no
5. Asthma	yes	no	12. Kidney involvement	yes	no
6. Bleeding Disorders	yes	no	13. Liver involvement	yes	no
7. Anemia	yes	no	14. Blood transfusions	yes	no

15. Is your child allergic to penicillin, aspirin or any other medicine .... yes no
16. Is your child taking any medication at the present time .... yes no
17. Is your child under medical care now .... yes no
18. Has your child ever had an unfavorable reaction from previous dental or medical care .... yes no
19. Any previous hospitalizations? .... yes no
20. Date of last medical examination ______________________
21. Date of last dental exam ______________________

IF ANY OF THE ABOVE ANSWERS ARE YES, PLEASE EXPLAIN:

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I hereby authorize Dr. Lisa Ritter-Kahn, Dr. Douglas S. Schildhaus, Dr. Celia Spatt, Dr. Harry Tsotsos and/or their associates to render any services deemed necessary in the treatment of ______________________ after consent by parent.

Date: ______________ ______________________
SIGNATURE OF PARENT OR GUARDIAN

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.