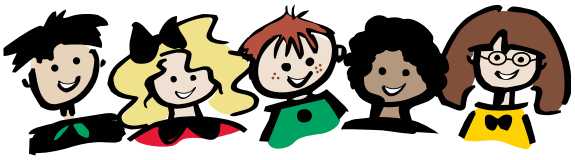

Howard C. Kotkin, D.D.S.

Pediatric Dentistry

Permit No. 4071

33 Main Street • Suite 203 • Chatham, NJ 07928

(973) 635-6444

GENERAL INFORMATION

CHILD'S NAME	NICKNAME	DATE OF BIRTH	SEX
			❑ M ❑ F

NAME & AGE OF SIBLING(S)

ADDRESS			TEL #
CITY	STATE	ZIP CODE	EMAIL

WHO MAY WE THANK FOR REFERRING YOU?	PEDIATRICIAN

PARENT'S NAME	CELL #	OCCUPATION/EMPLOYER	WORK TEL #
PARENT'S NAME	CELL #	OCCUPATION/EMPLOYER	WORK TEL #

MEDICAL INFORMATION

Please elaborate if you answer Yes to any of the following questions:

Is your child allergic to any medications, food, or other? ❑ Yes ❑ No _____

Is your child under medical treatment? ❑ Yes ❑ No _____

Is your child taking any medications? ❑ Yes ❑ No _____

Has your child ever been hospitalized or had surgery? ❑ Yes ❑ No _____

Does your child have a history of: (please check if yes and elaborate below)

❑ heart murmur ❑ asthma ❑ bleeding disorder ❑ heart trouble ❑ sensory disorders ❑ Diabetes

❑ rheumatic fever ❑ seizures ❑ tuberculosis ❑ Autism ❑ other _____

_____

_____

DENTAL INFORMATION

Has your child ever been to the dentist? ❑ Yes ❑ No

Has your child ever had a bad experience at the dentist? ❑ Yes ❑ No

Has your child stopped sucking habits (thumb, pacifier, etc)? ❑ Yes ❑ No

Please list any questions you would like to have answered _____

_____

_____

Approval for treatment and form completed by: _____

SIGNATURE / RELATIONSHIP