Dr. Diya Chadha DMD, FRCD(C)
Certified Specialist in Pediatric Dentistry

Dr. Karim Kanani DMD
Certificate in Pediatric Dentistry

SmileTown Dentistry

Unit 111, 7511 120th Street
North Delta, BC V4C 0C1
P: (778) 564-1095
F: (778) 564-1098
office@smiletownnorthdelta.com
www.smiletownnorthdelta.com

Patient Information and Medical History Form

How did you hear about us?: _____

Patient Name: _____ DOB: _____
Home Address: _____ Phone #: _____
Fathers Name: _____DOB: _____Cell #: _____ Email: _____
Mothers Name: _____DOB: _____Cell #: _____ Email: _____

In case of an emergency and a parent cannot be reached, please contact:
Name: _____ Relation: _____ Cell #: _____

Medical Home

Who is your child's physician? _____ Doctor's Phone # _____
Is your child currently under the care of the primary care physician for a specific condition?
( ) Yes ( ) No. If yes, please explain: _____
Is your child under the care of a pediatric specialist for a medical, emotional or behavioral condition? ( ) Yes ( ) No. If yes, please explain: _____

Hospitalizations and Surgeries

Was your child born full term? ( ) Yes ( ) No. If no, at how many weeks gestation? _____
Did your child spend time in the Neonatal Intensive Care Unit after birth? ( ) Yes ( ) No. If yes, how long?
_____
Has your child had surgery? ( ) Yes ( ) No. If yes, please explain: _____
Has your child been hospitalized for a medical condition or because of significant injuries?
( ) Yes ( ) No. If yes, reason, date and outcome: _____
Has your child spend time in the Pediatric Intensive Care Unit? ( ) Yes ( ) No. If yes, reason, date and outcome: _____

Medications

Is your child presently taking medications prescribed by a doctor? ( ) Yes ( ) No. If yes, please list: _____
Is your child presently taking over the counter medications? ( ) Yes ( ) No. If yes, please list:
_____

Allergies and Adverse Reactions

Does your child have ANY allergies? ( ) Yes ( ) No. If yes, please list: _____
Has your child had a bad reaction to any of the following? ( ) Yes ( ) No. If yes, please circle all that apply:

Local Anesthetics	Penicillin or other antibiotics	Sedative medications	Other
Sulfa drugs	Codeine or other narcotics	Latex	
Seasonal allergies	Food (Peanuts, Egg, Soy)	Dyes	

Explain any circled responses and describe type of reaction: _____

Diseases or Conditions

Has your child had any of the following:

Complications during pregnancy or at birth? ( ) Yes ( ) No. If yes, please explain: _____
_____

PLEASE TURN OVER →

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Any birth defects or inherited conditions? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any blood or bleeding problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any ears, eyes, nose or throat problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any heart problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any lung or breathing problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any nutritional or digestive system problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any problems in the genitourinary system? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any problems with the brain or nervous system? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any developmental conditions? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any mental or behavioral conditions? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any hormone problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any bone and muscle problems? ( ) Yes ( ) No. If yes, please explain: _____
_____
Any skin problems? ( ) Yes ( ) No. If yes, please explain: _____

I hereby certify that I have read and understood the previous information and that it is accurate, true and complete to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. If there is any change in my child's health, I will inform SmileTown Dentistry at my child's next dental appointment without fail.

Signature: _____ **Date**: _____

Dental History

Is today your child's first dental visit? ( ) Yes ( ) No. If no, how long since their last visit? _____ months
If no, has your child had dental X-rays taken in the past? ( ) Yes ( ) No. If yes, when? _____
If your child has seen another dentist, please provide the name of the doctor or office:
_____
Has your child ever had an unpleasant dental experience? ( ) Yes ( ) No. If yes, please explain: _____
_____

How is your child's dental health? ( ) Poor ( ) Average ( ) Excellent
Does your child have dental pain at the present time? ( ) Yes ( ) No.
Has your child sought dental care on an emergency basis? ( ) Yes ( ) No
Has your child injured his/her teeth, mouth or head? ( ) Yes ( ) No.
Does your child have or do any of the following: ( ) Yes ( ) No. If yes, please circle all that apply:

Thumb or finger sucking	Mouth breathing	Nail biting	Lip sucking
Use a baby bottle	Breastfeeding	Use a pacifier	Bad breath
Tongue thrusting	Teeth grinding		