

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

Dr. Karim Kanani DMD  
Certificate in Pediatric Dentistry



Suite 430 - 4460 Beresford Street  
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### 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  
Use a baby bottle  
Tongue thrusting

Mouth breathing  
Breastfeeding  
Teeth grinding

Nail biting  
Use a pacifier

Lip sucking  
Bad breath