

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

Dr. Karim Kanani DMD
Certificate in Pediatric Dentistry



Unit 110, 20780 Willoughby Town Centre Dr
Langley, BC V2Y 0M7
P: (604) 371-2830
F: (604) 371-2831
office@smiletownlangley.com
www.smiletownlangley.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 →

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

Dr. Karim Kanani DMD
Certificate in Pediatric Dentistry



Unit 110, 20780 Willoughby Town Centre Dr
Langley, BC V2Y 0M7
P: (604) 371-2830
F: (604) 371-2831
office@smiletownlangley.com
www.smiletownlangley.com

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