TOPSMILES PEDIATRIC DENTISTRY AND ORTHODONTICS
246 ST ANNE'S RD
WINNIPEG, MB R2M3A4
431 317 7777 /431 305 0901 fax

NEW PATIENT FORMS/ MEDICAL HISTORY (child)

How did hear about us: Friend_____ Google_____ Instagram_____ Facebook_____
Referral _____ Sign/ Walk by_____ Other_____

NAME: _____

BIRTHDATE (MM/DD/YY): _____AGE: _____ SEX (M/F): _____
HOME ADDRESS: _____
CITY_____ POSTAL CODE: _____
EMAIL ADDRESS_____
HOME NUMBER: _____ MOBILE NUMBER: _____
*MANITOBA MEDICAL #*_____*PHIN* _____ *(9DIGIT)*
*TREATY NUMBER*_____ *EIA (social Assistance)*_____

Primary Insurance	*2nd Insurance*
_____	_____
*Group #*_____	*Group #*_____
*Certificate #*_____	*Certificate #*_____
Insurance under (name)	*Insurance under (name)*
_____	_____
DOB	*DOB*
_____	_____
Address (If different from above)	*Address (if different from above)*
_____	_____

FOR MINORS:
PARENT'S/GUARDIAN'S NAME: _____
OCCUPATION: _____
REFERRING DENTIST: _____
REASON FOR CONSULATION: _____

DENTAL HISTORY

PREVIOUS DENTIST: _____ LAST DENTAL VISIT: _____
OFFICE ADDRESS: _____ OFFICE PHONE: _____

MEDICAL HISTORY

NAME OF PHYSICIAN: _____ SPECIALTY: _____PHONE _____

Please sign back of page

1.0 Child in good health? YES NO

1. Child under medical treatment now? YES NO
   If so, what is the condition being treated? _____
2. How often does your child brush their teeth _____?
3. Have there been any injuries to the child's teeth YES NO
   If yes, please explain_____
4. Has your child ever had a peculiar or adverse reaction to any medications YES NO
5. Are there any diseases or medical problems that run in the family YES NO
   If yes, please explain_____
6. Child ever had a serious illness or surgical operation.? YES NO
7. If so, what illness or operation? _____
8. Has the child ever been hospitalized? YES NO
   If so, when, and why? _____
9. Is the child taking any prescription/non-prescription drugs? YES NO
   If so, please specify: _____
10. Is the child allergic to any of the following: YES NO
    ( ) Local Anesthetics (ex. Lidocaine) ( ) Penicillin , Antibiotics
    ( ) Sulfa Drugs ( ) Aspirin ( ) Latex

    Does child have any other allergies _____
    Does child require EPI pen YES____ NO_____

Does the child have or had any of the following? Check which apply: YES NO

( ) High Blood Pressure	( ) Heart Disease	( ) Cancer/Tumors
( ) Low Blood Pressure	( ) Heart Murmur	( ) Anemia
( ) Epilepsy/ Convulsions	( ) Hepatitis/ Liver Disease	( ) Angina
( ) AIDS or HIV Infection	( ) Rheumatic Fever	( ) Emphysema
( ) ASD (autism)	( ) ADD/ADHD	( ) Cerebral palsy
( ) Sexually Transmitted Disease	( ) Hay Fever/ Allergies	( ) Bleeding Problems
( ) Stomach Troubles/ Ulcers	( ) Respiratory Problems	( ) Blood Diseases
( ) Fainting Seizures	( ) Hepatitis/ Jaundice	( ) Head Injuries
( ) Rapid Weight loss	( ) Tuberculosis	( ) Arthritis/Rheumatism
( ) Radiation Therapy	( ) Swollen Ankles	( ) Thyroid Problems
( ) Joint Replacement/ Implant	( ) Kidney Disease	( ) Stroke
( ) Fetal Alcohol Syndrome	( ) Diabetes	( ) Chest Pain
( ) Heart Attack	( ) Asthma	

( ) Others_____

I Certify that I have read and understand the above questions. If I had questions about this form, they were answered to my satisfaction. I will not hold my dentist, or any members of his/her staff, responsible for any errors or omission that I may have made in completing this form.

_____ _____

Patient/Parent/Guardian Name and Signature Date