Kidz-Teeth
SPECIALIST PAEDIATRIC DENTISTS

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NEW PATIENT FORM

Full Name: _____

Date of Birth: _____ **Age:** _____ ☐ **Female:** ☐ **Male:** ☐ **Other:**

Address: _____

E-mail: _____ **Phone:** _____

Other Children (Name/Ages): _____

Parent's Name: _____

Referred By: _____

MEDICAL HISTORY

Allergies: _____

Current Medications: _____

_____

Previous General Anaesthetics: _____

TICK IF YOUR CHILD HAS ANY

☐ Asthma
☐ Autism
☐ Diabetes
☐ Heart Disease
☐ Cancer Treatment
☐ Bleeding Disorder
☐ Disability
Other: _____

Previous injuries to teeth: _____

Reason for Seeking Specialist Care:

☐ Referred by Dentist
☐ Previous Anxious experience
☐ Other
☐ Trauma to teeth

Signature: _____ **Date:** _____