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toothfairykids.ca
Unit 210 B– 1916 Lonsdale Ave.
North Vancouver BC V7M 2K2

Tooth Fairy Kids
Pediatric Dentistry

Dr. Tila Bahri Iraei
DMD, MSc, FRCD(C)
Certified Specialist in Pediatric Dentistry

Date:

New Patient Form

General Information

Patient's First Name (Required) | Patient's Middle Name | Patient's Last Name (Required) | Preferred Name

Gender
○ Male ○ Female ○ Other

Date of Birth | Age | Personal Health Number

Address | City

Province | Postal Code | Country | Email | Cell Phone

Physician Name | Address | Phone

Pharmacy Name | Address | Phone

1st Legal Guardian Information

First Name | Middle Name | Last Name | DOB

Relationship to the patient

Address (If different from above) | City | Province

Postal Code | Country | Occupation (Optional)

Email Address | Cell Phone | Other Phone

Ins. Company's Name | Ins. Subscriber's Name

Ins. Group Number | Ins. ID / Certificate

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2nd Legal Guardian Information

First Name | Middle Name | Last Name | DOB

Relationship to the patient

Address (If different from above) | City | Province

Postal Code | Country | Occupation (Optional)

Email Address | Cell Phone | Other Phone

Ins. Company's Name | Ins. Subscriber's Name

Ins. Group Number | Ins. ID / Certificate

Medical and Dental History

Please check the correct answer if your child has had any of the following:

- ☐ Rheumatic Fever
- ☐ Asthma/Lung disease
- ☐ Pregnancy
- ☐ Recurrent Headaches
- ☐ Diabetes
- ☐ Cancer/Tumors
- ☐ Mouth Breathing
- ☐ Prematurity Birth Defects
- ☐ Stomach Ulcers
- ☐ Vision Problem
- ☐ Blood Disorders
- ☐ Developmental Problems
- ☐ Epilepsy
- ☐ Meningitis
- ☐ Cerebral Palsy
- ☐ Speech Issues
- ☐ Endocrine
- ☐ Bone Disorders
- ☐ Cleft Lip/Palate
- ☐ Malignant Hypothermia
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Snoring/Sleep Apnea
- ☐ Bleeding Problems
- ☐ Tuberculosis
- ☐ Hearing Problem
- ☐ Birth Defects
- ☐ Infectious Disease
- ☐ Celiac
- ☐ AIDS/HIV
- ☐ Hemophilia
- ☐ Inherited Condition
- ☐ Anemia
- ☐ Fainting Spells
- ☐ ADD/ADHD
- ☐ Social/ Emotional/Behavioural Disorders
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Autism/ ASD
- ☐ Complications before or during birth
- ☐ Liver Disease
- ☐ Convulsions
- ☐ Enlarged Tonsils
- ☐ Blood Transfusion
- ☐ Skin Issues
- ☐ Syndromes

If any of the above items were selected, please specify:

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Medical and Dental History

Does your child have any allergies to food, antibiotics, sedatives, latex, metals, acrylics, dyes, nuts or other medications?

○ Yes ○ No If yes, please specify

Does your child visit the physician regularly

○ Yes ○ No Date of last visit

Is your child taking any medication now?

○ Yes ○ No If yes, please specify

Is your child up to date on immunization against childhood diseases?

○ Yes ○ No Notes

Has your child been hospitalized?

○ Yes ○ No If yes, please specify When? Where?

Why?

Do you have any concerns about your child's teeth?

○ Yes ○ No If yes, please specify

Has your child ever been to the dentist?

○ Yes ○ No If yes Dentist Name Last dental visit date

Has your child had any problems or unpleasant reactions with dental treatment?

○ Yes ○ No

Has your child had any of the following treatments?

☐ Local Anesthesia ☐ Fluoride Treatment ☐ X-Ray

☐ Extractions ☐ Restorative Dentistry (Filling) If yes, when?

☐ Orthodontist ☐ General Anesthesia

Has your child ever injured their mouth, teeth or head?

○ Yes ○ No If yes, please specify

Does your child participate in any sports or other activities?

Does your child wear a mouthguard during these activities?

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Preventive

Does your child use Fluoridated toothpaste?

○ Yes ○ No

When are your child's teeth brushed:

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime

Who brushes their teeth:

☐ Parent ☐ Child ☐ Other

Are your child's teeth flossed?

○ Yes ○ No How often?

Which of the following applies to your child's diet?

Snacks between Meals ○ Rarely ○ 1–2 times a day ○ 3 or more times a day

Candy, Soft Drinks, Other Sweet ○ Rarely ○ 1–2 times a day ○ 3 or more times a day

Please let us know about past and current feeding and childhood habits

	Past	Current	Not Applicable	Age When Stopped
Breast Feeding				
Baby Bottle				
Sippy Cup				
Thumb/Finger Sucking				
Pacifier				
Teeth Grinding/Clenching				

Are there any other children in the family? ○ Yes ○ No

How did you hear about us?

☐ Consent (Required)

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted, if necessary, to obtain information required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be needed to determine the necessary treatment. I assume financial responsibility for dental services rendered for my child. Should my child be referred by ToothFairy Kids to any other doctor for consultation and/or treatment, I consent that medical records will be forwarded. I also consent to sharing all treatment information with my child's other guardian(s).

Date

Signature (Required)

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Additional Information

Please tell me more about your child by answering the following questions. This will help us connect much quicker and better during our dental appointments.

What is your child's...

Favourite TV show/cartoon?

What is your child's favourite game?

What is your child's favourite music?

What is your child's favourite food?

What is your child's favourite colour?

What is your child's favourite activity?

What is your child's best friend's name?

What is your child's hero?

What would be considered the best treat for your child?

Do you have a pet? If yes, what is your pet's name?

What is your child's favourite place?

Anything we should AVOID talking about?

Anything else that you consider important, please add: