Dr. Gayle Wagman
Dr. Michelle Crystal

416-651-2422
2568 EGLINTON AVENUE WEST,
TORONTO, ONTARIO M6M 1T4

NEW PATIENT FORM FOR CHILDREN AND TEENS

NAME DATE OF BIRTH

NAME OF PARENT OF GUARDIAN FILLING OUT FORM

MEDICAL INFORMATION

IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANYTHING OTHER THAN REGULAR CARE? ☐ YES ☐ NO

IF SO, FOR WHAT?

ARE YOUR CHILD'S IMMUNIZATIONS CURRENT? ☐ YES ☐ NO

PLEASE LIST ANY ALLERGIES (E.G. MEDICATION, LATEX)

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN

HAS YOUR CHILD HAD GENERAL ANAESTHETIC? ☐ YES ☐ NO

IF SO, REASON

DOES YOUR CHILD HAVE OR HAD ANY HISTORY OF THE FOLLOWING

HEART MURMUR	☐ YES	☐ NO	HEART DISEASE OR RHEUMATIC FEVER	☐ YES	☐ NO
FAINTING OR DIZZINESS	☐ YES	☐ NO	ASTHMA OR LUNG DISEASE	☐ YES	☐ NO
SEIZURES/EPILEPSY	☐ YES	☐ NO	BLEEDING PROBLEMS OR BRUISING	☐ YES	☐ NO
HORMONE ISSUES	☐ YES	☐ NO	KIDNEY DISEASE	☐ YES	☐ NO
DIABETES/ENDOCRINE DISORDERS	☐ YES	☐ NO	STOMACH ISSUES (E.G. IBS, CELIAC DISEASE)	☐ YES	☐ NO
CANCER, DIAGNOSIS & TREATMENT	☐ YES	☐ NO			
GENETIC DISORDER	☐ YES	☐ NO	PSYCHOLOGICAL ISSUES	☐ YES	☐ NO

FAMILY PHYSICIAN OR OTHER HEALTH CARE PROVIDER NAME PHONE

Dr. Gayle Wagman
Dr. Michelle Crystal

416-651-2422
2568 EGLINTON AVENUE WEST,
TORONTO, ONTARIO M6M 1T4

DENTAL INFORMATION

IS THIS THE FIRST VISIT TO THE DENTIST? ☐ YES ☐ NO

IS THIS AN EMERGENCY VISIT? ☐ YES ☐ NO

IS THERE A SPECIFIC DENTAL PROBLEM? PLEASE DESCRIBE

ANY INJURY TO HEAD, MOUTH, OR TEETH? ☐ YES ☐ NO

ANY MOUTH HABITS?
(E.G. THUMBSUCKING, NAIL BITER) ☐ YES ☐ NO

ANY HISTORY OF

☐ CAVITIES ☐ TOOTHACHES ☐ PAIN ☐ BROKEN TEETH ☐ INFECTIONS ☐ MISSING TEEH

WHEN AND HOW OFTEN DOES YOUR CHILD BRUSH?

WITH ASSISTANCE? ☐ YES ☐ NO

WHAT TYPE OF WATER DOES YOUR CHILD DRINK?

☐ TAP ☐ FILTERED ☐ BOTTLE WATER

HAS YOUR CHILD HAD DENTAL FREEZING (LOCAL ANAESTHETIC)? ☐ YES ☐ NO

HAS YOUR CHILD HAD ANY UNHAPPY EXPERIENCES WITH DENTAL CARE? ☐ YES ☐ NO

WHAT'S YOUR CHILD'S ATTITUDE TOWARD TODAY'S VISIT?

PERSONAL INFORMATION

CHILD'S FAVOURITE TOY, HOBBY, TV SHOW, SPORT

NAME OF SCHOOL

ANY BEHAVIOURAL OR LEARNING ISSUES (E.G. AUTISM, ADHD) PLEASE DESCRIBE

HOW WOULD YOU EXPECT YOUR CHILD TO BEHAVE IN OUR OFFICE?

WOULD YOU DESCRIBE YOUR CHILD AS

☐ SHY ☐ APPREHENSIVE ☐ OUTGOING

DOES YOUR CHILD HAVE EXCESSIVE WORRIES? ANXIOUS OR DEPRESSED?

IS THERE SOMETHING PARTICULAR YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD OR FAMILY?

PATIENT CONSENT

I, THE UNDERSIGNED, CERTIFY THAT ALL OF THE ABOVE MEDICAL AND DENTAL INFORMATION IS TRUE TO MY KNOWLEDGE AND I HAVE NOT OMITTED ANY PERTINENT INFORMATION. I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OF ADVISABLE, INCLUDING THE USE OF LOCAL ANAESTHETIC AS INDICATED, AND I WIL ASSUME RESPONSIBILITY FOR FEES ASSOCIATES WITH THESE PROCEDURES.

PATIENT(PARENT, GUARDIAN) SIGNATURE

Date