Tam Orthodontics and Pediatric Dentistry

CONFIDENTIAL

Patient Medical/Dental History Form (Under Age 18)

Date: _____

Patient Last Name: _____ Patient First Name: _____ Preferred Name: _____

Gender: F☐ M☐ Other ☐ Birth Date: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Cell Phone: _____ E-Mail: _____

PHN #: _____ Status #: _____

Referred by: _____

School: _____ Grade: _____

Hobbies, Activities: _____

Dental Insurance Information (if applicable):

Primary Policy Holder's Name: _____ Birth Date: _____

Employer: _____

Insurance Company: _____ Policy Plan #: _____

Subscriber ID: _____

Secondary Policy Holder's Name: _____ Birth Date: _____

Employer: _____

Insurance Company: _____ Policy Plan #: _____

Subscriber ID: _____

Parent/Guardian:

Custodial parent(s) name(s): _____

Father's Full Name: _____ Occupation: _____

Address (if different from patient) _____

Cell phone: _____ Home phone: _____

Work phone: _____

Dr. Isaac Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Samuel Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Timothy Tam
MSc, DMD, FCDS (BC)
Certified Specialist in Pediatric Dentistry

Tam Orthodontics and Pediatric Dentistry

Mother's Full Name: Occupation:

Address (if different from patient)

Cell phone: Home phone:

Work phone:

Dentist/Physician:

Patient's Dentist: City:

Last Seen: Reason:

Next Appointment:

Other dentist/dental specialists seen now - Name:

Reason:

Family Physician:

Physician Name: City:

Last Seen: Reason: `

Other medical/health care providers seen now - Name:

Reason:

General Information:

What concerns you about your child's teeth?

What concerns your child about his/her teeth?

How does your child feel about dental or orthodontic treatment?

Why did you select our office?

Does your child play a musical instrument?

Brother/Sister name: Age:

Had Orthodontic Treatment? ☐ Had Dental work done under General Anesthesia? ☐

Brother/Sister name: Age:

Had Orthodontic Treatment? ☐ Had Dental work done under General Anesthesia? ☐

Brother/Sister name: Age:

Had Orthodontic Treatment? ☐ Had Dental work done under General Anesthesia? ☐

Brother/Sister name: Age:

Had Orthodontic Treatment? ☐ Had Dental work done under General Anesthesia? ☐

Have any other family members been treated in this office? Please name them:

Dr. Isaac Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Samuel Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Timothy Tam
MSc, DMD, FCDS (BC)
Certified Specialist in Pediatric Dentistry

Tam Orthodontics and Pediatric Dentistry

Patient Health Information:

Do you take antibiotic pre-medication before any dental procedures? _____

Does the patient currently have (or ever had) a substance abuse problem? _____

Do you think that any of your child's activities affect his/her face, teeth or jaws? How?
_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

Medical History: (Please check if patient has had any of the following)

- o Heart Murmur
- o Heart Disease
- o Diabetes
- o Hepatitis
- o HIV Positive
- o Asthma/Sinus problems
- o Tuberculosis
- o Emotional Disorders
- o Cancer/Tumour
- o Immune System Problems
- o Liver Disease
- o Blood Disorders
- o Bleeding Problems
- o Kidney Disease
- o Premature Birth
- o Vision Problems
- o Hearing Problems
- o Learning Disability
- o Convulsions
- o Epilepsy
- o Seizures, fainting spells or neurologic problems?
- o Excessive bleeding or bruising tendency
- o Eczema
- o Skin Disorders
- o Blood Transfusion
- o Meningitis
- o Emotional, sensory or developmental issues
- o High or low blood pressure

Does your child have a health problem? Yes: ☐ No: ☐

Has your child been hospitalized? Yes: ☐ No: ☐

Dr. Isaac Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Samuel Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Timothy Tam
MSc, DMD, FCDS (BC)
Certified Specialist in Pediatric Dentistry

Tam Orthodontics and Pediatric Dentistry

Does your child have any Allergies? (food, medication, etc.)

- ☐ Latex (gloves, balloons)
- ☐ Metals (jewelry, clothing snaps)
- ☐ Acrylics
- ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ Aspirin
- ☐ Ibuprofen (Motrin, Advil)
- ☐ Penicillin
- ☐ Other antibiotics _____
- ☐ Plant Pollens
- ☐ Animals
- ☐ Foods
- ☐ Other substances _____

Dental History:

Now or in the past, has the patient had (please check the following):

- ☐ Erupting teeth very early or very late?
- ☐ Primary (baby) teeth removed that were not loose?
- ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ Chipped or injured primary or permanent teeth?
- ☐ Any sensitive or sore teeth?
- ☐ Jaw fractures, cysts, infections?
- ☐ Any teeth treated with root canals or pulpotomies?
- ☐ Frequent canker sores or cold sores?
- ☐ History of speech problems or speech therapy?
- ☐ Difficulty breathing through nose?
- ☐ Mouth breathing habit or snoring at night?
- ☐ Frequent habit of thumb/finger sucking?
- ☐ Frequent habit of tongue thrust?
- ☐ Frequent habit of fingernail biting?
- ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ Frequent habit of lip sucking?
- ☐ Tooth grinding or clenching?
- ☐ Clicking, locking in jaw joints?
- ☐ Soreness in jaw muscles or face muscles?
- ☐ Has your child been treated for “TMJ” or “TMD” problems?
- ☐ Any broken or missing fillings?
- ☐ Any serious trouble associated with dental treatment? Please explain: _____
- ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

How often does your child brush? _____ **Floss?** _____

Dr. Isaac Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Samuel Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Timothy Tam
MSc, DMD, FCDS (BC)
Certified Specialist in Pediatric Dentistry

Tam Orthodontics and Pediatric Dentistry

Family Medical History:

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

Release and Waiver:

I, _____, being the (guardian) of the above named patient hereby, give consent to Dr. Timothy/Isaac/Samuel Tam to perform treatments, operations, sedation and anesthesia that may be necessary to maintain optimum oral health.

Date: _____ Parent/Guardian Signature: _____

I authorize release of any information regarding my child's dental treatment to my dental insurance company.

Date: _____ Parent/Guardian Signature: _____

I have read the above questions and understand them. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist of any changes in my child's medical or dental health.

Date: _____ Parent/Guardian Signature: _____

Optional:

I hereby consent to the participation in taking of photographs and video for the patient above for educational purposes. (Dr.Tam teaches at the faculty of dentistry at the University of British Columbia)

Date: _____ Parent/Guardian Signature: _____

Dr. Isaac Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Samuel Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Timothy Tam
MSc, DMD, FCDS (BC)
Certified Specialist in Pediatric Dentistry