TAN DENTAL SURGERY

www.tandentalsurgery.com

New Child Form

Name (as per MyKad): _____

Gender: M / F Date of Birth: _____ Email: _____

General information	**Yes**	**No**
Has your child had previous orthodontic treatment?	☐	☐
Is your child presently in dental pain?	☐	☐
Has your child experienced any injuries to face, mouth or teeth?	☐	☐
Do your child's gums bleed when they brush?	☐	☐
Are you aware of your child's jaws clicking or popping?	☐	☐
Have you noticed your child grinding his/her teeth?	☐	☐

Brief medical history	**Yes**	**No**
Does your child have a history of any major illness?	☐	☐
Has your child ever been involved in a serious accident?	☐	☐
Is your child taking any medication?	☐	☐
Is your child allergic to any medication, latex or metal?	☐	☐
Are there any medical conditions we have not asked that you feel we should be aware of?	☐	☐