A/Prof Harleen Kumar
BDSc DCD (Paed Dent) FPFA
SPECIALIST PAEDIATRIC DENTIST

Kids Dental Sydney

Medical History Form

Please complete all questions on all three pages. The information requested will assist us in providing the best possible care for your child and will remain strictly confidential.

Date .....

PATIENT INFORMATION

Name of Child ..... Date of Birth .....

Gender ..... School .....

Patient's Address .....

Suburb ..... Postal Code .....

Parent 1 Name ..... Phone .....

Relationship ◯ Mother ◯ Father ◯ Legal Guardian ◯ Other

Mobile Phone .....

Parent 2 Name ..... Phone .....

Relationship ◯ Mother ◯ Father ◯ Legal Guardian ◯ Other

Mobile Phone .....

Main Phone* ..... Main E-mail* .....

Main phone number and email address will be used for appointment reminders.

WHO MAY WE THANK FOR THIS REFERRAL?

Dr ..... Practice .....

Have any of your other children seen A/Prof Kumar previously? ◯ Yes ◯ No

Name and address of your child's family doctor:

.....

Name and address of any medical specialists seen by your child:

.....

.....

MEDICAL HISTORY

Does your child have any medical conditions? ◯ Yes ◯ No

If yes, please specify the condition .....

Taking any medication or vitamins/supplements? ◯ Yes ◯ No

If yes, please specify the names and doses .....

Immunisations up to date? ◯ Yes ◯ No

Any allergies including to food, environmental or medication? ◯ Yes ◯ No

What are the reactions to each and are any anaphylactic? .....

Has your child ever been admitted to hospital? ◯ Yes ◯ No

Please list any operation or surgery your child has undergone .....

.....

Please tick anything that applies to your child:

- ☐ Behavioural or communication problems, sensory issues, autism spectrum disorder, ADD/ ADHD, developmental delay, intellectual disability?
- ☐ Mobility or other physical disabilities?
- ☐ Epilepsy, seizures, anxiety, depression, mental health conditions?
- ☐ Heart defects, congenital heart disease, murmur, endocarditis or rheumatic heart disease?
- ☐ Asthma, breathing or other lung conditions?
- ☐ Diabetes, endocrine disease, thyroid, bone or muscle disease or conditions?
- ☐ Liver or gastrointestinal conditions such as hepatitis, jaundice, reflux, Crohn's or Coeliac disease?
- ☐ Autoimmune conditions?
- ☐ Bleeding disorders, anaemia, platelet disorder, coagulation disorder?
- ☐ Cerebral palsy or seizures?
- ☐ Kidney disease or hepatitis?
- ☐ History of cancer, tumors, radiotherapy, chemotherapy or surgery?
- ☐ Other infectious diseases such as HIV, TB, drug-resistant infections?
- ☐ For older children: does your child smoke, drink alcohol or vape? Are they pregnant?

Further Details .....

.....

Name of Child ..... Date of Birth .....

DENTAL HISTORY

Is it your child's first dental check up? ◯ Yes ◯ No

Has your child recently had a toothache? ◯ Yes ◯ No

Has there been an accident involving teeth? ◯ Yes ◯ No

Has your child had a negative response to dental treatment? ◯ Yes ◯ No

What concerns you most about your child's teeth? .....

Does your child have any of the following habits? ☐ Snoring ☐ Noisy breathing during sleep

☐ Teeth grinding ☐ Mouth breathing ☐ Thumb sucking ☐ Dummy sucking

HEALTH INSURANCE DETAILS

Do you have private health insurance? ◯ Yes ◯ No

If yes, Fund Name ..... Membership No .....

Hospital Cover? ◯ Yes ◯ No Dental Cover? ◯ Yes ◯ No

PAYMENT

Full Name ..... Occupation .....

I certify the information supplied is accurate to the best of my knowledge. I will be responsible for any financial obligations incurred for my child's treatment, incidental costs incurred and/ or legal fees necessary to recover the same. Major treatment such as under general anaesthesia (GA) must be paid in full by 8 days prior to treatment, and any balance payable within 3 days. A 50% cancellation fee is applicable if GA treatment is cancelled less than 2 working days prior to the scheduled date.

I understand that for all other accounts, payment is required on the day of treatment. Person responsible for payment of account must sign at the bottom of the page.

Signed ..... Date .....



Kids Dental Sydney

Dentistry for Infants, Children and Adolescents

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