Pedo Planet Children's Dental Center

New Patient Form

Choose your nearest branch

- ○ Porur
- ○ Velachery
- ○ Anna nagar
- ○ New delhi

*** How did You know about Us**

*** Patient name**

***Nick name**

***Sex**

- ○ Male
- ○ Female

height

optional

***Mother's profession**

(It will help us to communicate better)

preferred

***Address**

Door No/Street Name/Locality

Zip

*** Mobile No 1**

Mobile No 2

optional

***Email**

Landline

optional

weight

optional

***Date of birth**

dd/mm/yy

***Parent/gaurdian name**

Blood group

***Father's profession**
(It Will Help Us To Communicate Better)

preferred

Does your child have any of these medical problem

Heart diease ○Yes ○No ○Don't know

Alergy to medicine ○Yes ○No ○Don't know

Ashma / wheezing ○Yes ○No ○Don't know

Jaundice ○Yes ○No ○Don't know

Epilepsy / seizure ? fits ○Yes ○No ○Don't know

Any Bleeding /clotting problem ○Yes ○No ○ Don't know

Any operation in the past ○Yes ○No ○Don't know

Are you taking any medicine ○Yes ○ No ○Don't know

Name of your child’s pediatric doctor

optional