THE BLOOR CLINIC KIDS

PAEDIATRIC DENTISTRY

3250 Bloor St. W, Suite 112, East Tower, Toronto, ON, M8X 2X9
437.774.8225 | thebloorclinickids.com

Patient Name: _____

Age: _____ Date: _____

Name of Guardian: _____

Contact Tel.: _____ (mobile | home | work)

Email: _____

Xrays: ❑ emailed ❑ sent with patient ❑ to be taken

Medical Alert: _____

❑ please provide complete care
❑ treatment requested

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
E D C B A	A B C D E
Right	Left
E D C B A	A B C D E
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Clinical Concern: _____

_____

_____

_____

_____

Appointment Date: _____ Time: _____

Referring Doctor: _____

Office Tel.: _____ Email: _____