Alpharetta Children's Dentistry & Orthodontics

Child's Name: ______________________ What does your child like to be called? __________
Date of Birth: __________ Age: ______ Male Female Grade Level: ______ School: __________
Child's Physician: ______________________ Approximate Date of Last Physical Exam: __________
Patient's Hobbies, Interests, Pets, etc.: ______________________
Other children and their ages: ______________________
Reason for visiting our office today: Checkup Decay Habit Orthodontics Emergency Other
Orthodontic Concerns: ______________________

YES NO Is your child under the care of a physician for other than routine care?
If yes, please explain: ______________________

YES NO Does your child have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?
If yes, please circle which one. If your child has a heart murmur, who diagnosed it? __________

YES NO Does your child have any drug allergies or has your child ever had a reaction to a drug?
If yes, please list the drug(s) and the reaction(s): ______________________

YES NO Does your child take any medication on a regular basis?
If yes, please list: ______________________

YES NO Is your child taking any medication at this time that he/she does not normally take on a regular basis?
If yes, please explain: ______________________

YES NO Has your child EVER been a patient in a hospital?
If yes, please explain: ______________________

YES NO Has your child EVER been seen in an emergency room for ANY reason?
If yes, please explain: ______________________

YES NO Does your child have or does anyone in your family have a condition called methylenetetrahydrofolate reductase deficiency (MTHFR) or hyperhomocysteinemia?

YES NO Does your child have any known allergy to nickel? If yes, describe allergy: __________

Please circle any condition your child currently has or has ever had:

Adrenal Disorder	Ear/Eye Disorder	Liver Disease	Intellectual Impairment	Hepatitis
Hearing Problem	Allergy	Muscle Disorder	Behavior Issue	Asthma
Intestinal Problem	Congenital Birth Problem	Nose/Throat Disorder	Speech Issue	Autism
Abnormal Bleeding	Heart Condition	Seizures	Kidney Problem	ADD/ADHD
Blood Disease	Endocrine Problem	Skin Disorder	Physical Impairment	Asperger's
Bone Disorder	HIV/AIDS	Cancer	Stomach Problem	Sensory Issues
Brain Disorder	Learning Difficulty	Tumor	Breathing Problem	
	Lung Disorder	Diabetes		

YES NO Has your child ever seen a pediatric dentist before? If yes, approximate date of last exam: __________
YES NO Has your child ever been seen by a regular general dentist before? If yes, approximate date of last exam: ______
YES NO Do you expect your child to be uncooperative?
YES NO Does your child drink unfluoridated water?
YES NO Does your child take fluoride tablets, fluoride drops, or vitamins which contain fluoride?
YES NO Has your child ever bumped any teeth? If so, when: ______________________
YES NO Has your child ever experienced facial pain or had problems with the jaw joints near each ear?
YES NO Is your child a "toothpaste eater"?
YES NO Has your child had a traumatic medical or dental experience? If yes, please explain: __________
YES NO Does your child suck his/her thumb, finger(s), pacifier, blanket, something else? If yes, what: __________
YES NO Does your child have difficulty breathing through the nose with his/her mouth closed?
YES NO Is there anything else you would like us to know or that we need to know about your child?
If yes, please explain: ______________________
YES NO Young Children Only: Does your child have a bottle to go to sleep?

THE ABOVE MEDICAL DENTAL AND MEDICATION HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGE IN THE ABOVE PRIOR TO ANY APPOINTMENT.

Signed (Parent/Guardian): ______________________ **Date:** __________

Print (Parent/Guardian): ______________________