Alpharetta Children's Dentistry & Orthodontics

Patient's Name: ______________________ What do you like to be called? ______________
Date of Birth: __________ Age: ________ Male Female
Primary Care Physician: ______________________ Approximate Date of Last Physical Exam: __________
Children: Yes No
Orthodontic Concerns: ______________________________

YES NO Are you under the care of a physician for other than routine care?
If yes, please explain: ______________________________

YES NO Do you have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?
If yes, please circle which one. If you have a heart murmur, who diagnosed it? ______________

YES NO Do you have any drug allergies or have you ever had a reaction to a drug?
If yes, please list the drug(s) and the reaction(s): ______________

YES NO Do you take any medication on a regular basis?
If yes, please list: ______________________________

YES NO Are you taking any medication at this time that you do not normally take on a regular basis?
If yes, please explain: ______________________________

YES NO Have you EVER been a patient in a hospital?
If yes, please explain: ______________________________

YES NO Have you EVER been seen in an emergency room for ANY reason?
If yes, please explain: ______________________________

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

YES NO Do you have any known allergy to nickel? If yes, describe allergy: ______________

Please circle any condition you currently have or have 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 Have you received any orthodontic treatment prior to today's visit? If yes, please explain: ______________
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YES NO Have you ever bumped any teeth? If so, when: ______________
YES NO Have you ever experienced facial pain or had problems with the jaw joints near each ear?
YES NO Have you ever had a traumatic medical or dental experience? If yes, please explain: ______________
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YES NO Did you suck your thumb, finger(s), pacifier, blanket, as a child? If yes, what: ______________
YES NO Do you have difficulty breathing through the nose with your mouth closed?
YES NO Is there anything else you would like us to know or that we need to know about your health? If yes, please explain: ______________________________

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 (Patient): ______________________ **Date:** __________

Print (Patient): ______________________