31001-01

Children's Healthcare of Atlanta

PATIENT IDENTIFICATION

Dental Clinic
Home Medication Reconciliation Form

Dear Patient, Parent, or Guardian:

Please list current medications your child is taking. This will allow us to have a complete list for consideration when choosing medications for your child today.

Does your child have any allergies to medicines? ☐ No ☐ Yes

If yes: Name medicine(s): _____

What happens when your child takes it? ☐ Rash ☐ Hives ☐ Swelling ☐ Vomiting ☐ Diarrhea

☐ Other _____

Please list all of your child's current medicines. ☐ **My child is not on any medicines right now.**

	Medicine Please list the name of each medicine your child takes	**How much does your child take?** Such as 2 ml, 5 mg, or 1 tsp.	**How often does your child take it?** Such as once a day, twice a day	**How does your child take this medication?** Such as by mouth or ear drops	**Why does your child take this medicine?**	**When was the last dose of this medication given?**
☐	Tylenol (Acetaminophen)				☐ Fever ☐ Pain	
☐	Motrin /Advil (Ibuprofen)				☐ Fever ☐ Pain	
☐	Antibiotic					
☐	Allergy/Cold/Cough medicine					
☐	Asthma/Wheezing medicine					
☐	Behavior medicines					
☐	Eye/Ear drops					
☐	Herbal medicines					
☐	Vitamins/Nutritional Supplements					
☐	Other medicines					

Source of information: ☐ Patient ☐ Parent ☐ Guardian ☐ Other

I have reviewed the list above, and based on the information supplied, validate that to the best of my knowledge these are the medicines that the patient is currently taking.

_____ _____ _____

Signature (Parent/Legal Guardian/Patient) Signature (Nurse/Physician/Provider) Date

34474-08

Children's Healthcare of Atlanta

Pediatric Dentistry
Patient Information

Patient Name: _____

Date of Birth: _____

PATIENT IDENTIFICATION

Today's Date: _____

Patient's Name: _____
Last Name First Name Middle Name

Patient's Residence: _____
Street Address

_____
City State Zip Code

Patient's Phone Number: _____ Patient's Date of Birth: _____

Cell Phone Number: _____ Email: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

☐ Female ☐ Male Marital Status of Natural Parents: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Partners

Referring Doctor's Name: _____ Phone Number: _____

Pediatrician's Name: _____ Phone Number: _____

Mother's Information	Father's Information
Full Name:	Full Name:
Social Security Number:	Social Security Number:
Date of Birth:	Date of Birth:
Employer:	Employer:
Occupation:	Occupation:
Work Address:	Work Address:
Work Phone:	Work Phone:
Home Address: ☐ Same as patient	Home Address: ☐ Same as patient
Home Phone Number: ☐ Same as patient	Home Phone Number: ☐ Same as patient

Dental Insurance Information	Medical Insurance Information	Medicaid Information
Member Number:	Member Number:	Member Number:
Plan Name:	Plan Name:	Plan Name:
Group Number:	Group Number:	Group Number:

Social Security Number of Insured: _____ Insurance 1-800 #: _____

Emergency Contact (not a parent): _____ Phone Number: _____

Relationship to patient: _____ Cell/Pager: _____

For Office Use Only:

Comments: _____

☐ Referring pediatrician on staff

34474-08

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Children's Healthcare of Atlanta at Scottish Rite

PEDIATRIC DENTISTRY

PATIENT BIOGRAPHICAL, MEDICAL, AND DENTAL HISTORY

Today's Date: _____ Time: _____

Patient's Name: _____
Last Name First Name Middle Name

Gender: ☐ Female ☐ Male Age: _____ Date of Birth: _____

Legal Guardian's Name: _____ Home Phone Number: _____

Cell Number: _____ Email: _____

Address: _____
Street Address City State Zip Code

Emergency Contact: _____ Referring Doctor: _____

DFACS/Social Workers Name: _____ Pediatricians Name: _____

Mothers Name/DOB: _____

Fathers Name/DOB: _____

Please check any of these conditions which your child presently has or has previously had:

	Anemia		Ear Disorders		Hyperactivity		Premature Birth
	Asthma		Seizure Disorders		Cerebral Palsy		Rheumatic Fever
	Bleeding Problems		Eye Disorders		Kidney Disease		Stomach Problem
	Bone Disorder		Fainting		Liver Disease		Skin Disease
	Brain Disorder		Heart Condition		Lung Disease		Speech Problem
	Shunt		Heart Murmur		Developmentally Delayed		Other medical condition
	Cancer		High Blood Pressure		Muscle Disorder		**None - To the best of my knowledge, my child is healthy and has not had any of these conditions**
	Diabetes		Hormone Disorder		Nose/Throat Disorder		

Is your child taking any medicines? ☐ No ☐ Yes, please list on the separate Medication Reconciliation form

Is your child allergic to any medicines or food? ☐ No ☐ Yes, please list and describe reactions: _____

Is your child allergic to latex? ☐ No ☐ Yes, please describe reaction: _____

Has your child ever experienced itching or swelling with dental visits, balloons, surgery, or any tests? ☐ No ☐ Yes

Has your child ever had any surgery (including ear tubes, tonsils and adenoids, etc)? ☐ No ☐ Yes, please list surgeries and the names of the hospitals where they were performed: _____

Has your child ever been hospitalized? ☐ No ☐ Yes, please list the reasons and the names of the hospitals: _____

Is this your child's first visit to the dentist? ☐ Yes ☐ No, please list dates and services performed: _____

What is your main concern about your child's dental health? _____

What is the source of your drinking water? ☐ City/County System ☐ Well ☐ Bottled

Has your child ever been given fluoride tablets, drops or rinses? ☐ No ☐ Yes

Has your child ever had any injuries to the mouth or face area? ☐ No ☐ Yes

Does your child have any of the following habits: finger/thumb sucking, pacifier? ☐ No ☐ Yes

How often are your child's teeth brushed? _____ By whom? _____

What is your preferred method of learning? ☐ Reading ☐ Listening ☐ Pictures/Video ☐ Demonstration ☐ Hands on

Additional Comments: _____

I acknowledge that the above medical information is correct. I hereby authorize the Dentistry staff to provide necessary treatment for my child, such treatment may include radiographs, photographs, local anesthetics, and other acceptable methods to accomplish these services. I will notify the Dentistry staff of any changes to the information above.

Legal guardian/Patient's Signature: _____ Date: _____ Time: _____