Children's Dental Zone
3455 Old Alabama Road
Alpharetta, GA 30022

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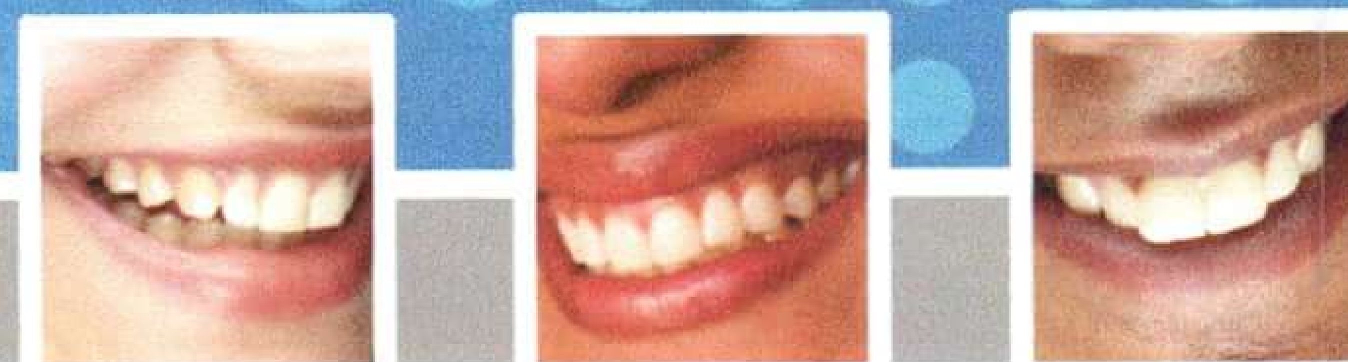

Welcome to Children's Dental Zone

Chart #. ____
FOR OFFICE USE ONLY

Patient Name: ____ Last ____ First ____ MI ____ Preferred Name

Title: ____ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____ Prev. Visit: ____ Email Address: ____

Phone: ____ Home ____ Work ____ Ext ____ Mobile Best time to call: ____

Address: ____ ____
____ City ____ State ____ Zip Code

Names of any siblings we have seen in our office:

____

What is the reason for seeing the dentist today?

☐ First Visit ☐ Check-up ☐ Pain ☐ Other

Has your child been to a different dental office in the last 6 months?

◯ Yes ◯ No

Name of your child's previous dentist?

____

Is there anything you would like to discuss with the doctor in private or not in front of your child?

◯ Yes ◯ No

Please indicate if your child has any of the following.

- [ ] *Pre-Med Required
- [ ] Acid Reflux
- [ ] ADHD/ADD
- [ ] Allergy - Codeine
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Seasonal
- [ ] Allergy- Other
- [ ] Anemia
- [ ] Artificial Joints
- [ ] Asperger's Disorder
- [ ] Asthma
- [ ] Autism
- [ ] Autoimmune Disorder
- [ ] Blood Disease
- [ ] Cancer
- [ ] Cerebral Palsy
- [ ] Developmental Delay
- [ ] Diabetes
- [ ] Dizziness
- [ ] Ear Tubes
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disorder
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] Herpes
- [ ] Hi/Lo Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Migraines/Headaches
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation/Chemo Tx
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Sensory Disorders
- [ ] Sinus Problems
- [ ] Sleep Problems
- [ ] Speech Delay
- [ ] Stomach Problems
- [ ] Stroke
- [ ] SVT
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

Please check any of the following that apply:

- [ ] Complications with or after dental treatment.
- [ ] Currently under the care of a physician due to a specific condition.
- [ ] Been seen by a cardiologist.
- [ ] Been admitted to a hospital in the last 5 years due to a surgery or illness.
- [ ] Any other conditions, diseases, etc. not listed above.

If any of the previous questions are marked, please explain:

Within the past year have there been any changes in your child's general health?

◯ Yes ◯ No

Is your child currently taking any prescription or non-prescription medications? (Please list name of medication, dosage and frequency)

What is the approximate date of your child's last medical exam?

Your Child's Pediatrician's Name and Phone Number:

How frequently does you child brush their teeth?

☐ 3+ a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

☐ By parent ☐ By child ☐ Both

How often does your child floss?

☐ Once daily ☐ Occasionally ☐ Never ☐ By parent ☐ By child

Is your child taking a fluoride supplement?

◯ Yes ◯ No

Does your child do any of the following?

☐ Lip sucking/biting ☐ Nail biting

☐ Finger/Thumb sucking/Pacifier ☐ Nursing/Bottle

☐ Grinds his teeth ☐ Snores

To the best of my knowledge, all the preceding information is true and correct and this will serve as my electronic signature. If there is any change in my child's health I will inform the office before or at their next dental appointment.

Signature: ______________________ Date: