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.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How much does your child take? Such as 2 ml, 5 mg, or 1 tsp.</th>
<th>How often does your child take it? Such as once a day, twice a day</th>
<th>How does your child take this medication? Such as by mouth or ear drops</th>
<th>Why does your child take this medicine?</th>
<th>When was the last dose of this medication given?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Tylenol (Acetaminophen)</td>
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<tr>
<td>□ Motrin /Advil (Ibuprofen)</td>
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<tr>
<td>□ Antibiotic</td>
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<tr>
<td>□ Allergy/Cold/Cough medicine</td>
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<tr>
<td>□ Asthma/Wheezing medicine</td>
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<tr>
<td>□ Behavior medicines</td>
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<tr>
<td>□ Eye/Ear drops</td>
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<tr>
<td>□ Herbal medicines</td>
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<tr>
<td>□ Vitamins/Nutritional Supplements</td>
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<tr>
<td>□ Other medicines</td>
<td></td>
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</tr>
</tbody>
</table>

□ My child is not on any medicines right now.

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
Children's Healthcare of Atlanta

Pediatric Dentistry

Patient Information

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: ________________________

Cell Phone Number: ________________________

Preferred Method of Contact: [ ] Home Phone  [ ] Cell Phone  [ ] Email

[ ] Female  [ ] Male  Marital Status of Natural Parents:

[ ] Married  [ ] Divorced  [ ] Widowed  [ ] Single  [ ] Separated  [ ] Partners

Reffering Doctor's Name:

Pediatrician's Name:

Mother's Information

Full Name: ____________________________

Social Security Number: ____________________________

Date of Birth: ____________________________

Employer: ____________________________

Occupation: ____________________________

Work Address: ____________________________

Work Phone: ____________________________

Home Address: [ ] Same as patient

Home Phone Number: [ ] Same as patient

Father's Information

Full Name: ____________________________

Social Security Number: ____________________________

Date of Birth: ____________________________

Employer: ____________________________

Occupation: ____________________________

Work Address: ____________________________

Work Phone: ____________________________

Home Address: [ ] Same as patient

Home Phone Number: [ ] Same as patient

Dental Insurance Information

Member Number: ____________________________

Plan Name: ____________________________

Group Number: ____________________________

Medical Insurance Information

Member Number: ____________________________

Plan Name: ____________________________

Group Number: ____________________________

Medicaid Information

Member Number: ____________________________

Plan Name: ____________________________

Group Number: ____________________________

Social Security Number of Insured: ____________________________

Insurance 1-800 #: ____________________________

Emergency Contact (not a parent): ____________________________

Relationship to patient: ____________________________

Cell/Pager: ____________________________

For Office Use Only:

Comments:

[ ] Referring pediatrician on staff
Children's Healthcare of Atlanta at Scottish Rite

Pediatric Dentistry

Patient Biographical, Medical, and Dental History

Today’s Date: __________________________

Patient’s Name: _________________________

Gender: □ Female □ Male

Age: _______ Date of Birth: _____________

Legal Guardian’s Name: ___________________

Cell/Pager Number: ______________________

Address: __________________________________________

Names and ages of brothers and sisters:

Whom may we thank for referring you: □ Friend □ Pediatrician □ Dentist □ Craniofacial Team □ Yellow Pages □ Other

Please list name(s) of referral source:

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Ear Disorders</td>
</tr>
<tr>
<td>Asthma</td>
<td>Seizure Disorders</td>
</tr>
<tr>
<td>Bleeding Problems</td>
<td>Eye Disorders</td>
</tr>
<tr>
<td>Bone Disorder</td>
<td>Fainting</td>
</tr>
<tr>
<td>Brain Disorder</td>
<td>Heart Condition</td>
</tr>
<tr>
<td>Shunt</td>
<td>Heart Murmur</td>
</tr>
<tr>
<td>Cancer</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Hormone Disorder</td>
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<tr>
<td></td>
<td>Hyperactivity</td>
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<tr>
<td></td>
<td>Cerebral Palsy</td>
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<tr>
<td></td>
<td>Kidney Disease</td>
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<td></td>
<td>Liver Disease</td>
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<td></td>
<td>Lung Disease</td>
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<tr>
<td></td>
<td>Mental Retardation</td>
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<tr>
<td></td>
<td>None - To the best of my knowledge, my child is healthy and has not had any of these conditions</td>
</tr>
</tbody>
</table>

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? ________

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, nitrous oxide analgesia, oral sedatives, 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: _______________________