Jordan Creek Pediatric Dentistry

1111 Jordan Creek Parkway,
West Des Moines IA 50266
(515) 222-1800

New Patient Registration and Health History

ABOUT YOUR CHILD

Child's Name
Preferred Name
Date of Birth
Gender ☐ Male ☐ Female
Age
Street Address
City
State
Zip Code
School

PRIMARY DENTAL INSURANCE

Policyholder
Date of Birth
SSN
Insurance Co.
Employer
Policy ID #
Group #

SECONDARY DENTAL INSURANCE

Policyholder
Date of Birth
SSN
Insurance Co.
Employer
Policy ID #
Group #

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for Jordan Creek Pediatric Dentistry.

Name

Signature

Date

PARENT 1 INFORMATION

Choose One: ☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian
Choose One: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Does this parent have custody of the child? ☐ Y ☐ N

Parent's Name
Date of Birth
SSN
Phone Number
Email Address
Street Address
City
State
Zip Code

I agree to text & email appointment reminders ☐ Y ☐ N

PARENT 2 INFORMATION

Choose One: ☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian
Choose One: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Does this parent have custody of the child? ☐ Y ☐ N

Parent's Name
Date of Birth
SSN
Phone Number
Email Address
Street Address
City
State
Zip Code

I agree to text & email appointment reminders ☐ Y ☐ N

HEALTH HISTORY

Is patient currently under the care of a physician? ☐ Y ☐ N
Are immunizations current? ☐ Y ☐ N
Date of last physical examination
Physician's name
Date of last dental exam
Name of previous dentist
City
State
List all current medications the child is taking

HEALTH HISTORY CONTINUED

Is your child having pain or discomfort at this time?	☐ Yes	☐ No
Is your child nervous about having dental treatment?	☐ Yes	☐ No
Has your child ever had a bad experience at a dentist?	☐ Yes	☐ No
Has your child been in the hospital in the past 2 years?	☐ Yes	☐ No
Has your child been under a physician's care in the past 2 years?	☐ Yes	☐ No
Does your family use fluoride toothpaste?	☐ Yes	☐ No

Check Yes or No to indicate if your child has had any of the following:

ADHD/ADD	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Intellectual Disabilities	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Learning Disabilities	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease or Attack	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Autism/Aspergers	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Birth Defects	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Persistant Cough	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Bruise easily	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Cancer (Type)	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No	Steroid Treatments	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Congenital Heart Problems	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Transplant	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	HIV Positive/ARC/AIDS	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Down Syndrome	☐ Yes	☐ No	Hives or Skin Rash	☐ Yes	☐ No	Other not listed	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Implant of any kind	☐ Yes	☐ No			

Details of any "Yes" answer or "Other" :

Allergies:

- ☐ None
- ☐ Codine
- ☐ Aspirin
- ☐ Iodine
- ☐ Penicillin
- ☐ Other
- ☐ Barbiturates
- ☐ Metals
- ☐ Sulfa
- ☐ Latex
- ☐ Local Anesthetic

Does/did your child have any of the following habits:

- ☐ Lip sucking/biting
- ☐ Thumb/finger sucking
- ☐ Nail biting
- ☐ Clenching/grinding teeth
- ☐ Toungue/cheek biting
- ☐ Nail biting
- ☐ Tongue thrust
- ☐ Bottle habit
- ☐ Pacifier
- ☐ Breast fed
- ☐ Chewing on objects
- ☐ Speech problems
- ☐ Mouth breather

AUTHORIZATION FOR TREATMENT

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I further authorize the taking of dental x-rays as may be considered necessary by the dentists at Jordan Creek Pediatric Dentistry to diagnose and/or treat my child's dental needs.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered, any deductible, and/or co-payment that my insurance does not cover.

Patient Name
Signature
Signor Name
Date