JORDAN CREEK
PEDIATRIC DENTISTRY

NEW PATIENT REGISTRATION AND HEALTH HISTORY

Date _____

Patient Information

Patient Full Name _____
Nickname _____
Address _____
City _____ State _____ Zip _____
Sex: M F Age ____ Birth date _____
Social Sec. # _____
Single Married Widow Separated Divorced
Home Phone # _____
Work Phone # _____
Cell Phone # _____

Name of School _____

Who may we thank for referring you to our office?

_____

Primary Insurance Information

Policy Holder Name _____
Relationship to Patient _____
Birth date _____ Social Sec. # _____
Name of Employer _____
Insurance Company _____
ID# _____ Group# _____

Secondary Insurance Information

Policy Holder Name _____
Relationship to Patient _____
Birth date _____ Social Sec. # _____
Name of Employer _____
Insurance Company _____
ID# _____ Group# _____

Mother's Information

Mother's Full Name _____
Address _____
City _____ State _____ Zip _____
Birth date _____ Social Sec. # _____
Single Married Widow Separated Divorced
Home Phone # _____
Work Phone # _____
Cell Phone # _____

Father's Information

Father's Full Name _____
Address _____
City _____ State _____ Zip _____
Birth date _____ Social Sec. # _____
Single Married Widow Separated Divorced
Home Phone # _____
Work Phone # _____
Cell Phone # _____

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name _____
Signature _____
Date _____

For Office Use Only Health History Information

Updated on ____/____/____ Parent Initials _____
Updated on ____/____/____ Parent Initials _____
Updated on ____/____/____ Parent Initials _____
Updated on ____/____/____ Parent Initials _____
Updated on ____/____/____ Parent Initials _____
Updated on ____/____/____ Parent Initials _____
Updated on ____/____/____ Parent Initials _____

Is the child currently under the care of a physician? Yes No Please explain: _____
Please describe the child's current physical health: Good Fair Poor Are Immunizations Current? Yes No
Please list all drugs that the child is currently taking: _____

CONTINUED ON BACK

Have you or any member of your family been seen by us before? Yes No

If yes, which family member(s)? _____

Date of last physical examination _____ Physician's Name _____

Date of last dental examination _____ Date of last dental x-rays _____

Previous Dentist Name _____ City _____ State _____

Are you having pain or discomfort at this time?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
Have you ever had a bad experience in a dental office?	Yes	No
Is there anything you would like to speak with the Doctor about in private?	Yes	No
Have you been a patient in the hospital during the past two years?	Yes	No
Have you been under the care of a medical doctor during the past two years?	Yes	No

Circle Yes or No to indicate if you have had any of the follow:

Autism	Yes	No	Hives or skin rash	Yes	No	Heart Disease or Attack	Yes	No
Mental Retardation	Yes	No	Herpes	Yes	No	Glaucoma	Yes	No
Heart Problems	Yes	No	Fainting or dizzy spells	Yes	No	*Steroid Treatment	Yes	No
Liver Disease	Yes	No	Eating Disorder	Yes	No	Arthritis	Yes	No
Heart Surgery	Yes	No	Epilepsy or seizures	Yes	No	*Any type of implant	Yes	No
High Blood Pressure	Yes	No	Persistent Cough	Yes	No	*Heart Murmur	Yes	No
Tuberculosis (TB)	Yes	No	Birth defects	Yes	No	*Mitral Valve Prolapse	Yes	No
*Rheumatic Fever	Yes	No	Asthma	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric Treatment	Yes	No	*Congenital Heart Problems	Yes	No	Hay Fever	Yes	No
Sickle Cell Disease	Yes	No	Hepatitis A (Infectious)	Yes	No	Use of tobacco products	Yes	No
Sinus Trouble	Yes	No	Hepatitis B (Serum)	Yes	No	Bruise easily	Yes	No
*Artificial Joints	Yes	No	Hepatitis C or other	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Anemia	Yes	No	Kidney Trouble	Yes	No
Blood Transfusion	Yes	No	Drug Addiction	Yes	No	Hemophilia	Yes	No
*Any type of Transplant	Yes	No	Cold Sores	Yes	No	Diabetes	Yes	No
Cancer (type:_____)	Yes	No	Other: _____					

ALLERGIES

☐ Aspirin	☐ Local Anesthetic	☐ Barbiturates
☐ Penicillin	☐ Codeine	☐ Sulfa
☐ Iodine	☐ Metals	☐ Latex

Other: _____

WOMEN

Are you pregnant now?	Yes	No
Are you currently breast-feeding?	Yes	No
Are you taking oral contraceptives?	Yes	No

Does/did the child have any of the following habits?

☐ Lip Sucking/Biting	☐ Nail Biting	☐ Chewing on Objects	☐ Clenching/Grinding Teeth
☐ Thumb/Finger Sucking	☐ Nursing Bottle Habits	☐ Tongue/Cheek Biting	☐ Used Pacifier
☐ Tongue Thrust	☐ Mouth Breather	☐ Speech Problems	☐ Breast Fed

AUTHORIZATION

I certify that I have read and understand 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 health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. **I further authorize the taking of dental x-rays as may be considered necessary by Dr. Burns 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 co-payment that my insurance does not cover.

Signature _____ Name of Patient _____ Date _____