Shadow Creek
PEDIATRIC ▪ DENTISTRY

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822 NE Alices Rd, Waukee, IA 50263

PATIENT

Patient's Name_____ Sex_____ Age_____

Nickname_____ SS#/SIN_____ DOB_____

School_____ Grade_____

Child's Home Address_____

City_____ State_____ ZIP_____ Phone_____

RESPONSIBLE PARTY

Name _____ Relationship_____

Address _____ Email_____

City_____ State_____ ZIP_____

Home Phone_____ Cell Phone_____ Work Phone_____

SS#/SIN_____ DOB_____

CONTACT INFORMATION

Name _____ Email_____

Home Phone_____ Cell Phone_____ Work Phone_____

Relationship_____

PRIMARY INSURANCE

Insured Name _____ Relationship_____

SS#/SIN_____ DOB_____

Employer_____ Date Employed_____ Occupation_____

Insurance Company_____ Group #_____ Employee #_____

Insurance Company Address & Phone#_____

SECONDARY INSURANCE

Insured Name _____ Relationship_____

SS#/SIN_____ DOB_____

Employer_____ Date Employed_____ Occupation_____

Insurance Company_____ Group #_____ Employee #_____

Insurance Company Address & Phone#_____

PLEASE INDICATE ANY CONDITION THAT YOUR CHILD HAS OR HAS HAD:

Abnormal Bleeding	☐YES ☐NO	Developmental Delay	☐YES ☐NO	Lung Disease	☐YES ☐NO
ADD/ADHD	☐YES ☐NO	Ear Disorders	☐YES ☐NO	Organ Transplant	☐YES ☐NO
AIDS or HIV Positive	☐YES ☐NO	Eating Disorders	☐YES ☐NO	Pacemaker	☐YES ☐NO
Anemia	☐YES ☐NO	Endocrine Disorders	☐YES ☐NO	Physical Disability	☐YES ☐NO
Arthritis	☐YES ☐NO	Epilepsy/Seizures/Convulsions	☐YES ☐NO	Premature Birth	☐YES ☐NO
Asthma	☐YES ☐NO	Excessive Bleeding	☐YES ☐NO	Psychological Disability	☐YES ☐NO
Autism Spectrum Disorder	☐YES ☐NO	Head Injuries	☐YES ☐NO	Psychiatric Treatment	☐YES ☐NO
Behavior Problems	☐YES ☐NO	Heart Murmur	☐YES ☐NO	Radiation Treatment	☐YES ☐NO
Blood Disease	☐YES ☐NO	Hemophilia	☐YES ☐NO	Respiratory Problems	☐YES ☐NO
Bone/Joint Problems	☐YES ☐NO	Hepatitis (Any Type)	☐YES ☐NO	Rheumatic Fever	☐YES ☐NO
Cancer/Tumor	☐YES ☐NO	High Blood Pressure	☐YES ☐NO	Sickle Cell Anemia	☐YES ☐NO
Cerebral Palsy	☐YES ☐NO	Injuries to Face/Mouth	☐YES ☐NO	Skin Conditions	☐YES ☐NO
Chemical Dependency	☐YES ☐NO	Intellectually Disabled	☐YES ☐NO	Speech Delay/Therapy	☐YES ☐NO
Cleft Lip/Palate	☐YES ☐NO	Jaundice/Liver Disease	☐YES ☐NO	Stomach, Liver or Kidney Problems	☐YES ☐NO
Congenital Heart Defect	☐YES ☐NO	Jaw Joint Pain	☐YES ☐NO	Thyroid Problems	☐YES ☐NO
Diabetes	☐YES ☐NO	Kidney Disease	☐YES ☐NO	Tuberculosis	☐YES ☐NO

Has your child had a recent upper respiratory infection? ☐ YES ☐ NO

If yes, please list_____

Has your child had a recent ear infection? ☐ YES ☐ NO

If yes, please list_____

Date of last dental visit _____

Previous dentist's name, address & phone number_____

Has your child had difficulty with dental visits? ☐ YES ☐ NO

If yes, please list_____

Child's physican name, address & phone number_____

Has your child had any previous hospitalizations/serious illnesses? ☐ YES ☐ NO

If yes, please list_____

Does your child currently take any medications? ☐ YES ☐ NO

If yes, please list_____

Does your children have a history of allergies/sensitivities/adverse reactions to any medications? ☐ YES ☐ NO

If yes, please list_____

Has your child have any a history of allergies to any other substances (latex, environmental)? ☐ YES ☐ NO

If yes, please list_____

Plese explain any medical conditions your child has that is not listed above:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

Signature of Patient, Parent or Guardian

X_____ Date_____