arcticdental
2023 Cedar Plaza Dr.
Muscatine, IA 52761
e-mail: smile@arcticdental.com
Phone: 563.607.5979 Fax: 563.316.2358

Jarod W. Johnson, DDS
Pediatric Dentist

Welcome to Arctic Dental!

Child's Name: _____ Birthdate: _____

Emergency Contact (non-parent) name and phone number: _____

How did you hear about our office?

Friend (Name): _____
Drive-By
Movie Theater
Google or other search engine
Radio
Other

Other Dentist (Name): _____
Pediatrician (Name): _____
Muscatine Magazine
Our Website
Sibling is a Patient already

Person(s) Responsible for Account

Primary Guardian's Information: Mother Step Mother Foster Mother Grandmother Legal Guardian
(Circle one) Father Step Father Foster Father Grandfather

Name:	Date of Birth:	Occupation:
Address:	SSN:	Employer:
City, St, Zip:	Marital Status:	Does the child live with you?
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
***What is the best number to contact you for confirmations? (Circle One) Home Work Cell		

Secondary Guardian's Information: Mother Step Mother Foster Mother Grandmother Legal Guardian
(Circle one) Father Step Father Foster Father Grandfather

Name:	Date of Birth:	Occupation:
Address:	SSN:	Employer:
City, St, Zip:	Marital Status:	Does the child live with you?
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
***What is the best number to contact you for confirmations? (Circle One) Home Work Cell		

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Health Information

Child's Full Name: _____ Nickname: _____ DOB:____/____/_____

Gender: _____ Race/Ethnicity: _____ Height: _____ Weight: _____

Date of last physical examination: _____

Name/address/phone of primary physician:

_____

Name/address/phone of medical specialists:

_____

Is your child under the care of a physician at this time? Reason _____	□ YES	□ NO
Is your child taking any medication (prescription or over the counter), vitamins or dietary supplements? List name, dose, frequency and dates started: _____	□ YES	□ NO
Has your child ever been hospitalized, had surgery or a significant injury or been treated in the emergency department? List date & describe: _____	□ YES	□ NO
Has your child ever had an adverse reaction or problem with anesthetic or sedative agent? Describe: _____	□ YES	□ NO
Has your child ever had a reaction or allergy to medication? List: _____	□ YES	□ NO
Is your child allergic to anything else (i.e. latex, materials, metals, acrylic, dye or foods)? List: _____	□ YES	□ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions	□ YES	□ NO
Problems with physical growth or development	□ YES	□ NO
Sinusitis, chronic adenoid/tonsil infections	□ YES	□ NO
Sleep apnea/snoring, mouth breathing, or excessive gagging	□ YES	□ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	□ YES	□ NO
Irregular heart beat or high blood pressure	□ YES	□ NO
Asthma, reactive airway disease, wheezing, or breathing problems	□ YES	□ NO
Cystic fibrosis	□ YES	□ NO
Frequent colds or coughs, or pneumonia	□ YES	□ NO
Frequent exposure to tobacco smoke	□ YES	□ NO
Jaundice, hepatitis, or liver problems	□ YES	□ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	□ YES	□ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	□ YES	□ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	□ YES	□ NO
Bladder or kidney problems	□ YES	□ NO
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	□ YES	□ NO
Rash/hives, eczema or skin problems	□ YES	□ NO
Impaired vision, hearing, or speech	□ YES	□ NO
Developmental disorders, learning problems/delays, or intellectual disability	□ YES	□ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures	□ YES	□ NO
Autism/autism spectrum disorder	□ YES	□ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	□ YES	□ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	□ YES	□ NO

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Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Attention deficit/hyperactivity disorder (ADD/ADHD)	□ YES	□ NO
Behavioral, emotional, communication, or psychiatric problems/treatment	□ YES	□ NO
Abuse (physical, psychological, emotional, or sexual) or neglect	□ YES	□ NO
Diabetes, hyperglycemia, or hypoglycemia	□ YES	□ NO
Precocious puberty or hormonal problems	□ YES	□ NO
Thyroid or pituitary problems	□ YES	□ NO
Anemia, sickle cell disease/trait, or blood disorder	□ YES	□ NO
Hemophilia, bruising easily, or excessive bleeding	□ YES	□ NO
Transfusions or receiving blood products	□ YES	□ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	□ YES	□ NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS	□ YES	□ NO

Provide Details Here:

Dental History

Does your child have any oral habits? If yes circle habits: pacifier thumb/digit sucking mouth breathing nail biting teeth grinding	□ YES	□ NO
Does your child brush or are his or her teeth brushed? If yes: How often? _____ times per day _____ times per week	□ YES	□ NO
How much toothpaste is used?		
Does he/she swallow it?	□ YES	□ NO
Does your child floss or are his or her teeth flossed? If yes: How often? _____ times per day _____ times per week	□ YES	□ NO

Does your child have any of the following:

□ Inherited dental characteristics	□ Mouth sores or fever blisters	□ Bad Breath
□ Bleeding gums	□ Cavities/decayed Teeth	□Toothache
□ Injury to teeth, mouth, or jaws	□ Jaw joint problems	□ Excessive Gagging

Has your child been examined or treated by another dentist? □ YES □NO
If YES: Date of first visit: _____ Date of last visit: _____
Reason for last visit: _____
Were x-rays taken of the teeth or jaws? □ YES □ NO Date of most recent dental x-rays: _____

Is there anything else we should know before treating your child? □ YES □ NO
If yes, describe:

_____ _____ _____
Signature of parent/guardian Relationship to child Date