Welcome to Oak Park Dentistry for Children

We, the Doctors and Staff at Oak Park Dentistry for Children, are committed to creating a positive attitude toward dentistry and oral health. Please take a few moments to fill out the following form. We look forward to working with you to maintain your child's dental health!

REASON FOR VISIT: DATE:			
Examination, X-rays if necessary, cleaning and fluoride treatment			
Orthodontic question or problem			
Pain, discomfort, accident or emergency care			
Consultation regarding			
PATIENT HISTORY RECORD			
FIRST NAME MIDDLE L	AST NAME	NICK NAME	
A CE DATE OF DADAY		WOME PROVIDE	
AGE DATE OF BIRTH	MALEFEMALE	HOME PHONE	
HOME ADDRESS	CITY	ZIP	
E-MAIL ADDRESS	CELL PHONE		
BY WHOM REFERRED	CHILD'S SCHOOL	GRADE	
FIRST NAMES OF THE CHILD'S SIBLINGS:			
DENTAL HISTORY:	MEDICAL HISTO	DRY CONTINUED:	
Yes No Has your child ever had any of the following medical		r had any of the following medical	
☐ ☐ Is this your child's first visit to the dentist? If not,	problems?		
approximate date of child's last visit			
	_		
☐ Is your child's water fluoridated?	Heart Mu	ırmur	
☐ ☐ Is your child taking any fluoride supplements?	Cancer		
Has your child ever had any jaw pain or tenderness			
Does your child brush their teeth daily?		Rheumatic Fever HIV+/AIDS	
Does your child floss their teeth daily?			
Does your child have any of the following habits?	Hemophi	111a	
thumb/ finger sucking/ pacifier		☐ ☐ Asthma	
grinding/bruxism		☐ ☐ Hepatitis ☐ ☐ Tuberculosis (TB)	
☐ ☐ nail biting ☐ ☐ mouth breathing		☐ ☐ Tuberculosis (TB) ☐ ☐ Congenital Heart Defect	
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		Convulsion / Epilepsy	
ARE THERE ANY OTHER CONCERNS YOU WOULD		Abnormal Bleeding	
LIKE TO BRING TO OUR ATTENTION? Administration Hearing Impairments			
2222 10 22210 10 0021111221110111	_	•	
	Please ex		
MEDICAL HISTORY:			
HeightWeight		Any stays in a hospital Please explain:	
Child's Physician		Liver problems	
Phone #Date of last visit		ps / Disabilities / Special Needs	
Please describe the child's current physical health:		xplain:	
GoodFairPoor	_	s to any drugs	
Please list all medications your child is currently taking	Latex Al	•	
		tions your child is allergic to:	
	Please discuss any m	edical conditions your child has:	

MOTHER'S IN		FATHER'S INFORMATION	
Mother's name	Single Divorced	Father's name	
MarriedS	Single Divorced	Father's name	
SS #	Birth date	SS #Birth date	
Address if differen	nt		
Home phone	Work phone		
Occupation		Occupation	
Employer's addres	ss	Employer's address	
DENTAL INS. C	O. NAME		
Phone		Dhone	
Cross #		_ Phone	
Deletion to notions		_ Group #	
Relation to patient		Relation to patient	
ADDITIONAL D	ENTAL INS. INFO. Subscriber	NameBirth date	
SS #	Employer	Ins. Co. Name	
Group #	Phone #	Address	
		1 11	
	ct: (list someone who does not live i		
name		Phone #	
appropriate materi The parent or	als and drugs. Parents will be consured a part of the companies that the companies	perform the necessary dental services my child may need, using the alted before any treatment is started. Child is responsible for payment at the time of service unless prior negements have been approved. Per year will be added to all past due balances. Charged for each check returned by the bank. Appointments or appointments not cancelled 24 hours in advance.	
Signature of I	Parent or Guardian	Date	
payment at th	ite: The parent or guardian who a ne time of service unless prior arra ed my child's health history and it		
DATE	SIGNATURE	COMMENTS	
DATE			
DATE	SIGNATURE		
DATE			
DATE	SIGNATURE	COMMENTS	
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