Welcome to Oak Park Dentistry for Children & Orthodontics

We, the Doctors and Staff at Oak Park Dentistry for Children & Orthodontics, 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 LAST NAME NICK NAME

AGE_____ DATE OF BIRTH_____ MALE____ FEMALE____ 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:

Yes No

☐ ☐ Is this your child's first visit to the dentist? If not, approximate date of child's last visit_____

_____

☐ ☐ Is your child's water fluoridated?
☐ ☐ Is your child taking any fluoride supplements?
☐ ☐ Has your child ever had any jaw pain or tenderness?
☐ ☐ Does your child brush their teeth daily?
☐ ☐ Does your child floss their teeth daily?

Does your child have any of the following habits?

☐ ☐ thumb/ finger sucking/ pacifier
☐ ☐ grinding/bruxism
☐ ☐ nail biting
☐ ☐ mouth breathing
☐ ☐ nursing bottle habits/ breast-feeding

ARE THERE ANY OTHER CONCERNS YOU WOULD LIKE TO BRING TO OUR ATTENTION?

_____
_____

MEDICAL HISTORY:

Height _____Weight _____
Child's Physician_____
Phone #_____Date of last visit_____
Please describe the child's current physical health:
Good _____Fair _____Poor _____

Please list all medications your child is currently taking:

_____
_____
_____

MEDICAL HISTORY CONTINUED:

Has your child ever had any of the following medical problems?

Yes No

☐ ☐ Blood Transfusion
☐ ☐ Heart Murmur
☐ ☐ Cancer
☐ ☐ Diabetes
☐ ☐ Rheumatic Fever
☐ ☐ HIV+/AIDS
☐ ☐ Hemophilia
☐ ☐ Asthma
☐ ☐ Hepatitis
☐ ☐ Tuberculosis (TB)
☐ ☐ Congenital Heart Defect
☐ ☐ Convulsion / Epilepsy
☐ ☐ Abnormal Bleeding
☐ ☐ Hearing Impairments
☐ ☐ Any Operations
Please explain:_____
☐ ☐ Any stays in a hospital
Please explain:_____
☐ ☐ Kidney / Liver problems
☐ ☐ Handicaps / Disabilities / Special Needs
Please explain:_____
☐ ☐ Allergies to any drugs
☐ ☐ Latex Allergy

Please list all medications your child is allergic to:

_____

Please discuss any medical conditions your child has:

PARENT #1 INFORMATION

Name_____
Married_____ Single_____ Divorced_____
SS #_____ Birth date_____
Address if different_____
_____
Home phone_____ Work phone_____
Cell phone_____
Occupation_____
Employer_____
Employer's address_____
_____
DENTAL INS. CO. NAME_____
_____
Address_____
Phone_____
Group #_____
Relation to patient_____

PARENT #2 INFORMATION

Name_____
Married_____ Single_____ Divorced_____
SS #_____ Birth date_____
Address if different_____
_____
Home phone_____ Work phone_____
Cell phone_____
Occupation_____
Employer_____
Employer's address_____
_____
DENTAL INS. CO. NAME_____
_____
Address_____
Phone_____
Group #_____
Relation to patient_____

ADDITIONAL DENTAL INS. INFO. Subscriber Name_____ Birth date_____
SS #_____ Employer_____ Ins. Co. Name_____
Group #_____ Phone #_____ Address_____
Relationship to patient_____

Emergency Contact: (list someone who does not live in household)
Name_____ Phone #_____

I understand that the information that I have given is correct to the best of my knowledge that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the office staff of Oak Park Dentistry for Children to perform the necessary dental services my child may need, using the appropriate materials and drugs. Parents will be consulted before any treatment is started.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

A late fee of 18% per year will be added to all past due balances.

A $ 25 fee will be charged for each check returned by the bank.

A $25 fee will be charged for missed appointments or appointments not cancelled 24 hours in advance.

Signature of Parent or Guardian_____Date_____

History Update: The parent or guardian who accompanies the child at each visit is responsible for payment at the time of service unless prior arrangements have been approved.
I have reviewed my child's health history and it is correct.

DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____
DATE_____SIGNATURE_____COMMENTS_____