

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
- _____ 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 _____

BY WHOM REFERRED _____ CHILD'S SCHOOL _____ GRADE _____

FIRST NAMES OF THE CHILD'S SIBLINGS: _____

DENTAL HISTORY:

Y N Is this your child's first visit to the dentist? If not, approximate date of child's last visit _____

Y N Is your child's water fluoridated?

Y N Is your child taking any fluoride supplements?

Y N Has your child ever had any jaw pain or tenderness?

Y N Does your child brush their teeth daily?

Y N Does your child floss their teeth daily?

Does your child have any of the following habits?

Y N thumb / finger sucking / pacifier

Y N nail biting

Y N mouth breathing

Y N 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?

Y N Blood Transfusion

Y N Heart Murmur

Y N Cancer

Y N Diabetes

Y N Rheumatic Fever

Y N HIV+/AIDS

Y N Hemophilia

Y N Asthma

Y N Hepatitis

Y N Tuberculosis (TB)

Y N Congenital Heart Defect

Y N Convulsion / Epilepsy

Y N Abnormal Bleeding

Y N Hearing Impaired

Y N Any Operations

Please explain: _____

Y N Any stays in a hospital

Please explain: _____

Y N Kidney / Liver Problems

Y N Handicaps / Disabilities / Special Needs

Please explain: _____

Y N Allergies to any drugs

Y N Latex Allergy

Please list all medications your child is allergic to:

Please list any medical conditions your child has:

MOTHER'S INFORMATION

Mother's 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 _____

FATHER'S INFORMATION

Father's 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 _____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____

Address (if different) _____ Home Phone _____ Work 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.

Signature of Parent or Guardian _____ Date _____

Medical History Update

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 _____