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 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 grinding/bruxism
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 Impairments
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 discuss 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 _____________
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 _____________
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 ____________________
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