

## 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 \_\_\_\_\_ 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:**

