



**Public Health**  
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Champaign-Urbana Public Health District  
www.c-uphd.org

# Champaign-Urbana Public Health District Child & Teen Dental Clinic



## Dental Patient Registration

Revised March 8, 2022

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  **Female**  **Male**

**Race**  Asian  Black or African American  American Indian or Alaskan  Hawaiian or Pacific Islander  White

**Ethnicity**  Hispanic or Latin  Non-Hispanic  Prefer not to answer  Unknown

What is your primary language? \_\_\_\_\_

**Parents or Guardians:**

**Name:** \_\_\_\_\_  Mother  Father  Legal Guardian

**Name:** \_\_\_\_\_  Mother  Father  Legal Guardian

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Primary Phone Number:** \_\_\_\_\_ **Secondary Phone Number:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Name of School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

If you or your child's school requests that we fax a Proof of Dental Exam form, do we have your permission to do so?  Yes  No

Is your child covered by Dental Insurance other than Illinois Medicaid?  Yes  No

**Name of Dental Insurance** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Please list any other adults (18 and over) who are allowed to bring your child to future dental appointments:**

**Name** \_\_\_\_\_ **Relationship to Child** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship to Child** \_\_\_\_\_

***Adult's photo ID must be shown at each visit.***

### Please do not leave any questions blank.

**Child's Medical Doctor(s)** \_\_\_\_\_ **Date of Last Visit** \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the child under current doctor care?  Yes, Reason? \_\_\_\_\_  No

**Child's current physical health:**  Good  Fair  Poor

Has your child had any difficulties during previous dental visits including behavioral problems?

Yes; please explain \_\_\_\_\_  No

What are your child's activities or interests? \_\_\_\_\_

Please list other family members seen at our clinic: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE CHECK any Medical Conditions your child has or has had in the past:**

**NO KNOW MEDICAL CONDITIONS**

- ADD, ADHD or related
- AIDS or HIV (Positive)
- Anemia, Hemophilia, Excessive Bleeding or other Blood Disorders Type?: \_\_\_\_\_
- Artificial Joints
- Asthma  
If check, do you use a nebulizer or inhaler?  
 Yes **PLEASE BRING INHALER TO EACH VISIT**  
 No
- Autism
- Blood Transfusion, date: \_\_\_\_\_
- Cancer, Type: \_\_\_\_\_
- Cerebral Palsy
- Chronic Stomach Problems
- Damaged or Artificial Heart
- Heart Surgery or planning Heart Surgery  
Are you required to pre-medicate?  Yes  No
- Other Heart or Cardiovascular Diseases:  
Please list: \_\_\_\_\_
- Diabetes, Type: \_\_\_\_\_

- Fainting Spells
- Epilepsy or Seizure Disorder
- Eczema
- Excessive Bleeding Problems or Disorders
- Frequent Hives or Skin Rashes
- Hearing Impaired and/or Vision Impaired (please circle)
- Hepatitis, jaundice, or other Liver Disease
- High or Low Blood Pressure (please circle)
- Tobacco, Alcohol or Drug Use: \_\_\_\_\_
- Kidney Disease
- Menstrual bleeding problems
- Physical Disabilities: \_\_\_\_\_
- Pregnant, Due Date: \_\_\_\_\_
- Psychiatric, Mental Disabilities or Behavioral Problems  
Please list: \_\_\_\_\_
- Sinus Problems, Seasonal Allergies or Hay Fever
- Sickle Cell Anemia
- Surgeries \_\_\_\_\_
- Chemotherapy / Radiation treatments for growths, tumors or TB
- Other diseases, conditions, or medical problems not listed above:  
\_\_\_\_\_

Please list all medications, oral contraceptives, supplements and multivitamins your child currently takes:

NONE \_\_\_\_\_

**Is your child allergic to any of the following?**

- No known allergies**
- Clindamycin (Cleocin)
- Erythromycin
- Penicillin / Amoxicillin / Augmentin
- Other Antibiotic \_\_\_\_\_

- Aspirin
- Codeine
- Ibuprofen
- Tylenol
- Other Pain Medication \_\_\_\_\_

- Iodine
- Latex (Gloves, etc.)
- Sulfa or Sulfite Drugs
- Cephalex (Keflex)

**"To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental provider of any changes in my child's medical status."**

**I authorize the dental staff at the Champaign-Urbana Public Health District to perform the necessary dental services my child may need. Services to include, but not limited to the following: x-ray, prophy (cleaning), fluoride, sealants, scale and root plane (STM), restorations, space maintainers, pulpotomy, extractions, root canal treatment (RCT), and dental education.**

**I hereby authorize submission of dental claims to my insurance carrier(s) and direct payment of the dental benefits to the Champaign-Urbana Public Health District."**

Parent's/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



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## Dental Clinic Guidelines

Revised 12/11/2019

**Thank you for choosing C-UPHD to provide the best dental care for your child!** Your child will continue to visit us for check-ups every 4-6 months until they are 18; if your child is still enrolled in high school at 18, they will need to show their student ID at each visit. We will continue to see them for 6 months following high school graduation.

**For your child's safety, this dental clinic follows CDC Infection Control & HIPAA Privacy Guidelines.**

In order to provide quality dental care to your child, we ask that you follow these guidelines:

- 1) **Bring your child's insurance card and parent's photo ID** to every appointment.  
If you have authorized other adult(s) that may bring your child, they must provide their photo ID.
- 2) **Stay in the building during the appointment.** A parent or authorized adult must bring children under age 18 to every appointment and stay until the appointment is complete.
- 3) **Call at least 24-hours ahead** if you cannot bring your child to their appointment: **(217) 531-4279**
- 4) **Be on time.** If you are late for your child's appointment, you may be asked to wait or reschedule.
- 5) **Appointments are limited. Effective January 1, 2020, if 2 appointments are missed, your family will be dismissed from the dental clinic for a period of 1 year, and referred to your insurance to locate a new dental provider.**
- 6) **Only you and the child being treated are allowed in the treatment area;**  
if you bring other children with you, they must stay with you or another adult in the lobby.
- 7) **Cell phones and food are not allowed in the treatment area.**

"I have read and understand the above Dental Clinic Guidelines and agree to follow them."

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Parent/Guardian Print Name

Signature

Date