Champaign-Urbana Public Health District
Children & Teens Dental Clinic

Dental Patient Registration

Revised September 15, 2017

Clinics located at:
201 West Kenyon Road
Champaign
&
1002 South Race Street
Urbana

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**	☐ Aspirin	☐ Iodine
☐ Clindamycin (Cleocin)	☐ Codeine	☐ Latex (Gloves, etc.)
☐ Erythromycin	☐ Ibuprofen	☐ Sulfa or Sulfite Drugs
☐ Penicillin / Amoxicillin / Augmentin	☐ Tylenol	☐ Cephalex (Keflex)
☐ Other Antibiotic ____________	☐ Other Pain Medication ____________	

"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** ____/____/______

Public Health
Prevent. Promote. Protect.

Champaign-Urbana Public Health District

Dental Clinic Guidelines

Revised 3/20/2017

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.
   Exception: At the Urbana School Health Center, Urbana High School Students are not required to have a parent present after their first appointment.

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) **If you missed an appointment, you will need to wait 2 months to schedule a new appointment.**
   a. After 3 missed appointments, you must schedule the next appointment in person.
   b. Frequent missed appointments can result in dismissal from the clinic.

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.
   - *At the Urbana School Health Center, space is very limited; you will be asked to wait in the reception are while your child is being treated.*

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."

______________________________	______________________________	______________
Parent/Guardian Print Name	*Signature*	*Date*