Champaign-Urbana Public Health District

Children & Teens Dental Clinic

Dental Patient Registration

Revised December 11, 2019

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 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."

_____ _____ _____

Parent/Guardian Print Name *Signature* *Date*