Champaign-Urbana Public Health District

Children's Dental Clinic

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

Dental Patient Registration

Revised August 1, 2014

Child's Name____ **Date of Birth**_____/_____/_____ ☐ **Female** ☐ **Male**

Race ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ White ☐ Unknown

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

What is your primary language? ____

Adult(s) bringing child to appointment:

Name: ____ ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____________

Name: ____ ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____________

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 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: ____

Child's Name ____ **Date of Birth** _____/_____/_____

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

- ☐ **No known medical conditions**
- ☐ ADD, ADHD or related
- ☐ AIDS or HIV (Positive)
- ☐ Anemia or Blood disorders
  please list: ______________________________
- ☐ Artificial Joints
- ☐ Asthma
  If check, do you use a nebulizer or inhaler?
  ☐ Yes ☐ No
  PLEASE BRING INHALER TO EACH VISIT
- ☐ Autism
- ☐ Blood Transfusion, date: ____________________
- ☐ Cancer, Type: ___________________________
- ☐ Cardiac Pacemaker
- ☐ Cerebral Palsy
- ☐ Chronic Stomach Problems
- ☐ Congenital (at birth) Heart Problems
- ☐ Damaged or Artificial Heart
- ☐ Other heart or cardiovascular diseases
  Type: ___________________________________
- ☐ Diabetes, Type:___________________________
- ☐ Epilepsy or Seizure Disorders
- ☐ Eczema
- ☐ Excessive Bleeding Problems or Disorders
- ☐ Fainting Spells
- ☐ Frequent Hives or Skin Rashes
- ☐ Hearing Impaired and/or Vision Impaired (please circle)
- ☐ Heart Murmur
  Are you required to pre-medicate? ☐ Yes ☐ No
- ☐ Heart Surgery or planning Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis, jaundice, or other Liver Disease
- ☐ High or Low Blood Pressure (please circle)
- ☐ History of Alcohol, Tobacco, or Drug use
- ☐ Kidney Disease
- ☐ Menstrual bleeding problems
- ☐ Physical Disabilities
  Please list:____
- ☐ Pregnant
- ☐ Psychiatric, Mental Disabilities or Behavioral Problems
  Please list: ____
- ☐ Seasonal Allergies or Hay Fever
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Surgery, Chemotherapy or X-Ray treatments
  for growths or tumors or tuberculosis
- ☐ Tobacco or Drug Use: ______________________
- ☐ Venereal Disease, Type: ______________________________
- ☐ 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	☐ Cephalexin (Keflex)
☐ Other Antibiotic: _____________________	☐ Other pain medications: ________________	

"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/Legal Guardian Signature________________________________ **Date**____/____/______

Dentist's Signature ____ **Date** ____/____/_____

Public Health
Prevent. Promote. Protect.

Champaign-Urbana Public Health District

Dental Clinic Guidelines
Effective August 1, 2014

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, we will continue to see them for 6 months following graduation. They will need to show their student ID at each visit.

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 Medicaid card and parent's photo ID** to appointments.
   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 will be asked to wait or reschedule.

5) **If you missed an appointment, you must wait 2 months to schedule a new appointment.**

   a. After 3 missed appointments, you must attend a Dental Orientation class before you may reschedule.

   b. Excessive missed appointments will result in dismissal from the clinic.

6) **Only you and the child being treated are allowed in the clinic area**; if you want to be with your child during treatment, please arrange for a friend or relative to care for other children.
   - *At the Urbana School Health Center, space is limited; you may be asked to wait in the reception are while your child is being treated.*

7) **Cell phones and food are not allowed in the clinic area.**

"I have read the Champaign-Urbana Public Health District Dental Clinic Guidelines, and agree to follow them."

______________________	______________________	__________
Parent/Guardian Print Name	***Signature***	***Date***