



Public Health
Prevent. Promote. Protect.

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?

<input type="checkbox"/> No known allergies <input type="checkbox"/> Clindamycin (Cleocin) <input type="checkbox"/> Erythromycin <input type="checkbox"/> Penicillin / Amoxicillin / Augmentin <input type="checkbox"/> Other Antibiotic _____	<input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol <input type="checkbox"/> Other Pain Medication _____	<input type="checkbox"/> Iodine <input type="checkbox"/> Latex (Gloves, etc.) <input type="checkbox"/> Sulfa or Sulfite Drugs <input type="checkbox"/> Cephalex (Keflex)
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"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, prophylaxis (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 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 area 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