Ottawa Children's Dentistry

1704 Polaris Circle, Ottawa, IL 61350 • (815) 434-6447 • www.ottawachildrensdentistry.com

Patient Registration and History Form

Tell Us About Your Child

Child's Name: _____ _____ _____ Preferred Name: _____
First M.I. Last

Child's Birthdate: _____ Child's Age: _____ ☐Male ☐Female Current School: _____

Home Address: _____ Home Phone #: _____
City State Zip

Please list any other siblings seen in this office: _____

Whom may we thank for referring you to our office (or how did you hear about us)? _____

Parent/Legal Guardian's Information

Parent/LG Name: _____ _____ _____ Relationship to Patient: _____
First M.I. Last

Social Security #: _____ Birthdate: _____ E-mail Address: _____

Address (If different from child): _____
☐Single ☐Married ☐Divorced ☐Separate ☐Widowed

Employer/Occupation: _____ Work Phone #: _____ Cell Phone #: _____
How may we contact you? ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email (unencrypted) ☐Text Message

Parent/LG Name: _____ _____ _____ Relationship to Patient: _____
First M.I. Last

Social Security #: _____ Birthdate: _____ E-mail Address: _____

Address (If different from child): _____
☐Single ☐Married ☐Divorced ☐Separate ☐Widowed

Employer/Occupation: _____ Work Phone #: _____ Cell Phone #: _____
How may we contact you? ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email (unencrypted) ☐Text Message

Who has legal custody of this child?: _____ Person responsible for payment of account?: _____

Insurance Information (Insurance card must be shown at time of visit.)

Primary Insurance

Insurance Co. Name: _____ Adress: _____ Phone #: _____

Policy Owner's Name: _____ _____ _____ Policy #: _____ Group #: _____
First M.I. Last

Policy Owner's Birthdate: _____ ID #: _____ Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Adress: _____ Phone #: _____

Policy Owner's Name: _____ _____ _____ Policy #: _____ Group #: _____
First M.I. Last

Policy Owner's Birthdate: _____ ID #: _____ Employer: _____

Person(s) Authorized to Bring Child to Visits

Parent/legal guardian must come to initial visit. I give my permission for the following individual to schedule visits, sign consents and treatment plans, make dental treatment decisions, discuss finances, and have access to health information in my absence. This authorization is valid until revoked by me in writing.

Name: _____ Name: _____
Relationship to Patient: _____ Relationship to Patient: _____

Dental History

Reason for today's visit: _____ If not first dental visit **ever**, ☐Previous ☐Present Dentist: _____
Date of the last: visit? _____ cleaning?:_____ dental x-rays?: _____

Does/Is your Child?

☐Yes ☐No Brush? How often? _____ ☐Yes ☐No Floss? How often? _____ (Caregiver assistance? ☐Yes ☐No)
☐Yes ☐No Drink well water or bottled water (Brand: _____)?
☐Yes ☐No Drink juice, soda, gatorade, chocolate milk, sweet tea, kool-aid (>1 cup per day total of all combines drinks listed)?
☐Yes ☐No Have jaw joint discomfort (TMJ pain)?
☐Yes ☐No Presently in dental pain? If yes, explain: _____
☐Yes ☐No Has your child ever experienced a dental or face injury? If yes, explain: _____
☐Yes ☐No Have/had cavities?
☐Yes ☐No Has this child ever had an unfavorable dental experience in the past? If yes, explain: _____
Fluoride Sources: ☐Toothpaste ☐City Water ☐Supplements ☐Rinse/Gel

Does/did this child have any of the following habits/conditions?

☐Yes ☐No Breast Fed (Until age: _____)
☐Yes ☐No Bottle Fed (Until age: _____)
☐Yes ☐No Pacifier (Until age: _____)
☐Yes ☐No Use Sippy Cup Between Meals
☐Yes ☐No Clenching/Grinding Teeth
☐Yes ☐No Bad Breath/Halitosis
☐Yes ☐No Gag Easily
☐Yes ☐No Tobacco
☐Yes ☐No Thumb/Finger Sucking
☐Yes ☐No Lip/Cheek Sucking/Biting
☐Yes ☐No GERD
☐Yes ☐No Speech Problems

Medical History

Is this child in good health? ☐Yes ☐No Child's Primary Physician: _____
Name/Phone of Medical Specialists (if seeing): _____
Current medications and dosages taken: _____
_____
Is this child allergic to any of the following: ☐Seasonal ☐Penicillin ☐Metal ☐Latex ☐Local Anesthetic ☐Food/Other:_____
Does this child have any medical conditions that require **Pre-Medication**? ☐Yes ☐No
Has this child ever been hospitalized or had a surgery? If yes, when and why?: _____

Has this child had/experienced any of the following:

☐Yes ☐No ADD/ADHD
☐Yes ☐No Anemia/Blood Disorder
☐Yes ☐No Asthma
☐Yes ☐No Autism
☐Yes ☐No Behavioral Issues
☐Yes ☐No Birth Defects/Cleft Lip or Palate
☐Yes ☐No Blood Transfusion History
☐Yes ☐No Cancer/Tumors/Leukemia
☐Yes ☐No Cerebral Palsy
☐Yes ☐No Chronic Ear Infections/Tubes
☐Yes ☐No Diabetes/Auto-immune Disease
☐Yes ☐No Developmentally Delayed
☐Yes ☐No Learning Disabilities
☐Yes ☐No Epilepsy/Seizures
☐Yes ☐No Fainting/Dizziness
☐Yes ☐No Gluten Free Diet
☐Yes ☐No G-Tube Feeding
☐Yes ☐No Headaches
☐Yes ☐No Heart Condition/Murmur
☐Yes ☐No Hemophilia/Abnormal Bleeding
☐Yes ☐No Hepatitis/Liver Disease
☐Yes ☐No HIV +/AIDS
☐Yes ☐No Hormone/Kidney/Bladder Disease
☐Yes ☐No Muscle/Bone/Skin Disorder
☐Yes ☐No Pregnant
☐Yes ☐No Respiratory Disease
☐Yes ☐No Sensory Issues
☐Yes ☐No Sinus Problems
☐Yes ☐No Sight/Hearing Impairment
☐Yes ☐No Tonsillitis
☐Yes ☐No Thyroid Disease
☐Yes ☐No Tuberculosis (TB)/MRSA
☐Yes ☐No Syndrome: _____
_____
_____
_____

Please explain any YES answers: _____
Please discuss any other medical condition that this child has had/has: _____
_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize the release (fax, email, mail, etc.) of information concerning my child's office visit to and/or from the primary care physician, family physician, referring physician or dentist, and insurance company. I request and authorize Dr. Laun/Wrobel and staff to examine, clean, and provide my child with comprehensive dental treatment including but not limited to fillings, crowns, nerve treatment, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental condition. I accept the reality that diagnosis and treatment plans may change due to further information (most common changes are root canal therapy and extraction), which may present during the procedures. I give my permission for the dentists to make any and all necessary changes to the treatment. I have been advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated; therefore no guarantee as to results of treatment can be made. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purpose. I understand that I am financially responsible for payment of any charges incurred on this child for dental treatment, any deductible, and any co-payment that my insurance does not cover. I authorize payment of all insurance reimbursement directly to Ottawa Children's Dentistry. I have been offered or I have fully read and understand the information about HIPAA and my privacy rights.

Parent/LG Signature: _____ Date: _____ Relationship to Child: _____

Updated w/ no changes: ☐_____ ☐_____ ☐_____ ☐_____ ☐_____ ☐_____
☐_____ ☐_____ ☐_____ ☐_____ ☐_____ ☐_____ ☐_____