

# Wicker Park Orthodontics CHILD REGISTRATION

1921 W. North Ave., Chicago, IL 60622 • 773-276-0335

Referred By \_\_\_\_\_ Date \_\_\_\_\_

Name of Patient \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Apt# City State Zipcode

Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex: **M** **F**

Father's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Apt# City State Zipcode

Mother's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Apt# City State Zipcode

S.S. No. (Father) \_\_\_\_\_ S.S. No. (Mother) \_\_\_\_\_

Birth Date \_\_\_\_\_ Birth Date \_\_\_\_\_

Other children who have been treated here:

\_\_\_\_\_  
Last First Relationship Dentist

Alternate contact in case of emergency \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Method of Payment:  CASH  CHECK  CREDIT Mastercard, VISA **Is Patient covered by insurance? If so:**

Name of Insurance Company Policy or ID# Subscriber Name

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AS PARENT OR LEGAL GUARDIAN, I ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF MY CHILD'S DENTAL TREATMENT INCLUDING CHARGES NOT COVERED BY MY DENTAL INSURANCE OR THIRD-PARTY PAYOR

Signature of Parent Requesting Care \_\_\_\_\_ Date \_\_\_\_\_

OFFICE USE ONLY:

# Child Health/Dental History Form



American Dental Association  
www.ada.org

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth
Parent's/Guardian's Name			Relationship to Patient	
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>				
Phone <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? <b>If you answer yes to any of the three items above, please stop and return this form to the receptionist.</b>				
<b>Has the child had any history of, or conditions related to, any of the following:</b>				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell
<input type="checkbox"/> Thyroid				
<input type="checkbox"/> Tobacco/Drug Use				
<input type="checkbox"/> Tuberculosis				
<input type="checkbox"/> Venereal Disease				
<input type="checkbox"/> Other _____				
<b>Please list the name and phone number of the child's physician:</b>				
Name of Physician _____			Phone _____	

## Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized? .....	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic? .....	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems? .....	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties? .....	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion? .....	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired? .....	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut? .....	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses? .....	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past? .....	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed? .....	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth? .....	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth? .....	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment? .....	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements? .....	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used? .....	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier? .....	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities? .....	27. <input type="checkbox"/>	<input type="checkbox"/>

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**For completion by dentist**

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Office Use Only:**  Medical Alert  Premedication  Allergies  Anesthesia Reviewed by \_\_\_\_\_  
Date \_\_\_\_\_