Eagle View Community Health System
"with an eye on your health"

Oquawka Site
PO Box 198
Oquawka, IL 61469
309-867-2770
877-350-2385 (toll-free)

Stronghurst Site
PO Box 240
Stronghurst, IL 61480
309-924-2424
866-346-1337 (toll-free)

PARENTS/LEGAL GUARDIANS FILL OUT

Date: _____ Child's Date of Birth: _____

Child's Name: _____ Preferred Name: _____
Last First Middle

Mailing Address_____ City/State_____

Zip_____ Telephone # _____

Gender: ❑ Male ❑ Female ❑ Undifferentiated
Please list preferred pronouns: _____

Gender Identity: ❑ Male ❑ Female ❑ Male to Female ❑ Female to Male ❑ Other (Please Specify): _____

Sexual Orientation: ❑ Bisexual ❑ Lesbian, Gay or Homosexual ❑ Choose not to disclose ❑ don't know ❑ Straight or Heterosexual ❑ Other (Please describe) _____

Race/Ethnicity: ☐ White (not Hispanic or Latino) ☐ Black/African American (not Hispanic or Latino) ☐ Hispanic or Latino (all races) ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

Father's Name: _____ Employer: _____ Business Phone: _____

Mother's Name: _____ Employer: _____ Business Phone: _____

Names and ages of other children in the family _____

Emergency Contact Name _____ Phone # _____

INSURANCE
Ins. Co. Name Policy Holder Policy Holder DOB & SS# Group Policy Employer & Phone #

_____

Child's Physician _____ Phone # _____

Last Visit to Physician_____/_____/_____ Pharmacy Name _____ Phone _____

Previous Dentist's Name_____ Date last seen _____

Have you ever been told your child needs antibiotics or premeds before treatment? Yes ☐ No ☐

Allergy to Sulfa Drugs, Latex, Penicillin, Aspirin, Codeine, or Other Drugs: Yes ☐ No ☐

Specify:_____
_____

List medications, vitamins or herbal supplements your child is currently taking:

_____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

Allergies/hay fever	Yes ☐ No ☐	Chicken Pox	Yes ☐ No ☐	Physical/Mental Cond.	Yes ☐ No ☐
Autism	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Fainting or dizziness	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Swollen Neck Glands	Yes ☐ No ☐
Bleeding Abnormally	Yes ☐ No ☐	Hepatitis Type _____	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Blood disease	Yes ☐ No ☐	Herpes	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Tumor or growth on	
Chemotherapy	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐	head or neck	Yes ☐ No ☐
Circulatory problems	Yes ☐ No ☐	Jaw Pain	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐
Congenital Heart Lesions	Yes ☐ No ☐	Handicap	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐
Cerebral Palsy	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐	Cough, persistent	Yes ☐ No ☐

Please explain any "Yes" answers: _____

Any other conditions/diseases or disorders known at this time: _____

Dental Health

Reason for today's visit _____ Date of last dental exam _____

Former Dentist _____ Date of last dental x-rays _____

Has your child has any serious trouble associated with any previous dental treatment? Yes ☐ No ☐

If yes, please explain _____

If your child in pain now? Yes ☐ No ☐ How many times does your child brush per day? _____ Floss? _____

Children 5 and Under:

Does your child have any finger, thumb, and/or pacifier habits? Yes ☐ No ☐

Who brushes your child's teeth? _____ How frequently? _____

Is toothpaste used on your child's toothbrush? Yes ☐ No ☐

Does your child breastfeed? Yes ☐ No ☐

Does your baby sleep with a bottle at night? Yes ☐ No ☐

Consent:

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services rendered. I authorize release of any information to my insurance company relating to my dental claims.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with *(name of child)*

   _____.

   Signature of Parent/Legal Guardian _____ Date _____