ORAL HEALTH IMPACT PROJECT

Cecil County

School:_____

Child's Room #_____

Child's Name_____

ORAL HEALTH SERVICES REGISTRATION FORM

IF YOU WOULD LIKE TO ARRANGE FOR YOUR CHILD TO RECEIVE DENTAL SERVICES, PLEASE COMPLETE THIS FORM. IF YOU HAVE QUESTIONS OR NEED HELP PLEASE CONTACT:

ORAL HEALTH IMPACT PROJECT
1-866-916-OHIP (6447)

PATIENT INFORMATION

Child's Name: _____
Gender: (circle one) Male / Female
Date of Birth: _____
Parent/Guardian: _____
Address: _____Zip_____
Home Phone: _____
Daytime Phone: _____
I would like someone to contact me with additional information:
Yes____ No____

PRIVATE DENTAL INSURANCE

Name of Ins. Company _____
Subscriber_____
Subscriber DOB_____
Card #_____
Group Number_____
Employer_____

Phone: 1-866-916-OHIP (6447)
E-mail:jbickley@ohip.us

PERMISSION FOR CHILD TO BE SEEN

_____YES, I give permission for my child:

_____
(Name of Child)

_____NO, I do not give permission

to be treated by the dentists representing Oral Health Impact Project. I understand that this consent will stay in effect while my child attends a school serviced by OHIP and that it is my responsibility to inform the dentist, dental hygienist and/or the school nurse of any changes in my child's medical history.

I understand this treatment may include any or all of the following: Dental Exam and Diagnosis including X-Rays, Cleaning, Topical Fluoride Application, Preventative Sealants.

I understand that my child may also be seen by the OHIP Dentist at the school for further dental treatment, if needed. I also give permission for my child to have minor fillings, removal of an infected nerve of a tooth (pulpotomy), with possible application of local anesthetic xylocaine most commonly called "Novocaine".

Medicaid Information

Med#__/__/__/__/__/__/__/__/__/__

Identification Information

_____
_____

I agree to the confidential release of information to:

1. ***my insurance carriers for the purpose of billing and corroboration of information.***
2. ***managed care program for enrollment if necessary.***
3. ***child, school, and nurse***

_____
(Parent/Guardian Sign and Date)

_____
(Relationship to Child)

ORAL HEALTH IMPACT PROJECT

MEDICAL INFORMATION

Medical History-(circle if appropriate)-Heart Murmur, allergies to medications (List)_____. Does your child have any heart disease that requires antibiotics prior to dental treatment? Yes____ No_____

Does your child have or has he/she ever had the following? (check where appropriate)	Yes	No
Rheumatic fever/heart disease	☐	☐
Kidney problems	☐	☐
Lung problems	☐	☐
Latex Allergy	☐	☐
Allergies-food, drugs, insect bites	☐	☐
Fainting or dizziness	☐	☐
Anemia (thin blood) or any blood diseases	☐	☐
Liver problems	☐	☐
Sinus problems/hay fever	☐	☐
Nervous Disorders	☐	☐
Epilepsy/Seizures	☐	☐
Hypertension (high Blood pressure)	☐	☐
Stomach or intestine problems (ulcer)	☐	☐
Joint replacement	☐	☐
Any hospitalizations other than birth	☐	☐

Explain _____

Does your child now have or ever had any disease or condition not mentioned above?_____

Current Medications_____
_____
_____
_____

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