

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: _____
 Home Phone: _____
 Daytime Phone: _____
 I would like someone to contact me with
 additional information:
 Yes ___ No ___

Private Health Insurance

Include a copy of back and front of insurance card

Name of Ins. Company _____
 Subscriber _____
 DOB _____
 Card # _____
 Group Number _____
 Employer _____

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

**ORAL HEALTH IMPACT
 PROJECT**

**PERMISSION FOR CHILD TO
 BE SEEN**

____ YES, I give permission for my child:

 (Name of Child)

____ NO, I do not give permission; reason for refusal:

_____ to be treated by the dentists representing Oral Health Impact Project. I understand that this consent will stay in effect while my child attends this school 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 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 with possible application of local anesthetic xylocaine most commonly called "Novocain".

Mass Health Information

Med# _____
 10 numbers on card

*I agree to the confidential release of information to my
 insurance carriers
 for the purpose of billing and corroboration of
 information.*

 (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 need to be pre-medicated for any medical condition prior to a dental procedure? Yes ___ No ___

If yes, for what? _____

Does your child have or has he/she ever had the following?
 (check where appropriate) Yes No

Rheumatic fever/heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>
Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies-food, drugs, insect bites	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Anemia (thin blood) or any blood diseases	<input type="checkbox"/>	<input type="checkbox"/>
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems/hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high Blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or intestine problems (ulcer)	<input type="checkbox"/>	<input type="checkbox"/>
Any hospitalizations other than birth	<input type="checkbox"/>	<input type="checkbox"/>

Explain _____

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

Current Medications _____

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