ORAL HEALTH IMPACT PROJECT

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 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 with possible application of local anesthetic xylocaine most commonly called "Novocain".

PA Medicaid Information

Med#__/__/__/__/__/__/__/__/__/__/__
10 numbers on card

CHIP Identification Information

____

____

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)

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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	☐	☐
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)	☐	☐
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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