

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**

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

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)

**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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