Center for Oral Health

Patient Registration

Center for Oral Health

Personal Information

Name: ____ Gender: ☐M ☐F

Date of Birth: ___/___/_____ Social Security:_______-______-__________

Mailing Address:____

____

Home phone # _______________Work phone #__________________ Cell phone #______________

Mother's Name:___________________________ Father's Name: _________________________

Email: ________________________________

Emergency Contact

Name: ____________________________ Relationship: __________________________

Address: ____

____

Insurance Information

Insurance company name: ______________________________

Date of Birth: _____/_____/______

Policy holder subscriber #: ________________________________

Patient Demographics

Ethnicity: ☐ White Caucasian ☐Asian ☐Hispanic ☐Black/African American ☐Other ______________

Medical History

Does the patient have a primary care physician? ☐ Yes ☐No

Physician name: ____________________________Physician Phone #: ______________________

Height: _______ft.______inches Weight:_________

Names of siblings: ____

Who lives with the child? ____

Family health history: ____

Indicate your child's health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your child have any recent surgeries or hospitalizations? __________________________________

Does your child have any allergies to medications, food, materials? ______________________________

Does your child have or have experienced any of the following conditions?

☐ Asthma	☐ Liver Problems	☐ Tuberculosis	☐ Hemophilia	☐ Rheumatic Fever
☐ Kidney Problems	☐ Hepatitis	☐ Lung Disease	☐ Heart Problems	☐ Sickle Cell
☐ Epilepsy/Seizures	☐ Diabetes	☐ Latex Allergy	☐ Emotional Disorder	☐ Other ___________

Dental History

What was done and when was the last exam? ___________________________________

Were radiographs taken? For what reason? ___________________________________

Has your child suffered any injuries to the head, mouth, and/or teeth? ___________________________

If yes, explain how and when: ___________________________________

Does your child participate in any contact sport activities? ___________________________________

If yes, which ones: ____

Does your child have any habits? (Thumb sucking, mouth breathing, etc.) ___________________________

What type of water does your child drink? ___________________________________

How many times does your child brush and floss? ____

Is fluoride toothpaste used? ____

What does your child like to eat? ____

Is your child fearful of the dentist? ____

General Information: I have elected to seek comprehensive dental care from Center for Oral Health (COH). If treatment is more advanced than the clinic can provide, I will be provided with a list of lowr   cost dental clinics in the area as a referral. I also understand that dental care is provided by a licensed dentist and highly trained staff, who are regulated by the Dental Board of California. They can be reached by calling 877r   729r   7789 or 916r   263r   2300 or emailing dentalboard@dca.ca.gov. I understand that I may ask questions regarding materials that may be used in dental procedures. I acknowledge that I have also received a copy of the "Patient Bill of Rights" and the "Privacy Notice." I understand that the contact information I provide will be used to remind me of appointments. I also understand that the contact information will be used to have voicemails left.

Health: If I have any changes in my health status, changes in my medications or any recent hospitalizations, I will inform COH. If I am taking a type of drug called bisphosphonates, I will inform my dentists as I may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatments may increase that risk.

Dental Records: I understand that the dental record, Xr   rays, photographs, models and any other diagnostic aids that relate to my treatment here, are the property of COH. I acknowledge that I have the right to inspect these records and/or receive a copy of them or to request that they be sent to another health care provider. In order to obtain a copy of my records I will need to complete and sign a Release of Information form.

Images: My picture may be taken upon registration to confirm my identification on all future visits to dental clinic. I give COH the right to use all audio and/or visual images captured during clinic for any educational, advertising, trade, promotional, or other lawful purpose related to COH. I agree that COH owns the copyright for these images and I waive all claims of invasion of privacy for defamation. ____ (Initial)

Consent: I consent to examination, Xr   ray, models, photographs, diagnostic testing for the development of my proposed treatment plan and I further consent to any treatment procedures, which are diagnosed and indicated on the treatment plan. I agree that all records are the property of COH.

Release: I understand my dental health care is not under warranty, expressed or implied. In addition, I agree to release, hold harmless and waive all claims, losses or damages resulting or relating to the treatment rendered hereunder personnel at COH.

My signature below indicates that I have read and understand the above information and am willing to comply with the foregoing, and that I am patient, the parent or guardian of the patient with authority to give consent, or that I am duly authorized by the patient as the patient's general agent to execute the above and accept it's terms.

Patient Name ____ Date__________

Signature of Patient/Parent or Guardian____________________________________

Name of Parent/Guardian (if applicable)____________________________________

Signature of Witness____