MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

DENTAL REGISTRATION FORM

Please complete this form so we can provide the best care possible. The information you share with us is part of your confidential medical record. Some infectious diseases must be reported to the Indiana State Department of Health in accordance with Indiana state law (IC 16-41-2-1).

PLACE LABEL HERE

PLEASE PRINT

Birth Date: ____ / ____ / ____ (MM DD YYYY) Social Security Number: ____-____-____

Legal Name: _____ (First Middle Last)

Other names used: _____ Maiden: _____

Address: _____ (Street address City State Zip Code)

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Email address: _____

Sex/Gender: ☐ Male ☐ Female ☐ Trans (choose one) ☐ male → female ☐ female → male

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Is the patient of a multiple birth? (twin, triplet, etc.) Check the box if the answer is Yes. ☐

Please answer both questions: Please select all that apply. *(This information is for statistical use only)*

1. What is this person's race?
   - ☐ African American or Black
   - ☐ American Indian or Alaskan Native - Specify tribe: _____
   - ☐ Asian Indian
   - ☐ Chinese
   - ☐ Filipino
   - ☐ Guamanian or Chamorro
   - ☐ Hawaiian Native
   - ☐ Japanese
   - ☐ Korean
   - ☐ Other Asian: _____
   - ☐ Other Pacific Islander: _____
   - ☐ Other Race: _____
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ White

2. Is this client Hispanic/Latino?
   - ☐ No, not Spanish/ Hispanic/Latino
   - ☐ Yes, Mexican, Mexican Am., Chicano
   - ☐ Yes, Puerto Rican
   - ☐ Yes, Cuban
   - ☐ Yes, other Spanish/ Hispanic/Latino - Specify: _____

Country of birth: _____

Insurance Information
Medicaid ID# _____
Medicare ID # _____

Smoking Status (Select one if over the age of 12) ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Parent or guardian information (if under age 18)

Name: _____ Date of birth: ____ / ____ / ____ (MM DD YYYY) Relationship: _____

Address: _____ Phone Number: (____) _____

In case of emergency, who should be contacted?

Name: _____ Phone Number: (____) _____

Acknowledgement of receipt of Notice of Privacy

I have received a copy of this office's Notice of Privacy Practices. *(You may refuse to sign this acknowledgement)*

Patient/Parent/Guardian signature: _____ **Date:** _____

Authorization for Services

I hereby authorize the Marion County Public Health Department to examine, test or provide services to the patient listed above. Test results and treatment will be explained to me as part of my visit today. If follow-up is needed or any test/exam results or appointment reminders, I will be contacted by a staff member.

Patient/Parent/Guardian signature: _____ **Date:** _____

HIPAA Refusal: Please complete if client refuses to sign the acknowledgement section. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (please specify)

_____ _____
Authorized Employee Name (Print) Title (Print)

_____ _____
Employee Signature Date

DENTAL REGISTRATION FORM - Page 2

Birth Date: ____ / ____ / ____ (MM DD YYYY)

Name: _____ (First Middle Last)

School Name: _____

Grade: _____

Please list everyone that lives with you

Name	Birthdate	Relationship	Gender	School	(Staff Use) MCPHD#

PATIENT CONTACT AUTHORIZATION

The Marion County Public Health Department allows you to request to receive communications regarding appointments, lab results, treatment and/or other health information. ***Please check all that apply:***

☐ I do not want any contact made.

Telephone Communication

Home Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Cell Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Work Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Other _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

☐ OK to leave a detailed message with: _____ (Name) _____ (Relationship)

Written Communication

☐ You may contact me by mail using my home address
☐ You may contact me by mail using my work/office address
☐ If you have any other special request, please list: _____

_____ _____
Patient Signature Date

If you change your mind after completing this authorization, you must submit a written cancellation of the authorization. This will not affect or undo any disclosure prior to this notification.

For Staff Use Only

Date	Additional Addresses	Zip Code	Home Phone	Other Phone

Other Hospital Patient Number: _____ Medicaid Caseworker: _____

MEDICAL HISTORY AND CONSENT

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Name: _____ Date of birth: _____ MCPHD#_____

Please cirlce any of the following, which the patient has had or has currently:

1. ADHD/ADD	12. Cold sores	23. Heart murmur	34. Lung disease	45. Skin rashes or hives
2. Alcoholism	13. Cortisone medication	24. Heart pacemaker	35. Night sweats	46. Swelling of ankles
3. Anemia	14. Diabetes	25. Heart surgery	36. Osteoporosis	47. Thyroid disease
4. Arthritis	15. Drug addiction	26. Hemophilia	37. Pain in jaw joints	48. Tuberculosis (TB)
5. Artificial heart valve	16. Emphysema	27. Hepatitis	38. Psoriasis	49. Venereal disease
6. Asthma or hay fever	17. Epilepsy or seizures	28. Herpes	39. Psychiatric treatment	50. Weight loss
7. Blood transfusions	18. Fainting or dizzy spells	29. High blood pressure	40. Radiation therapy	51. Yellow jaundice
8. Bruise easily	19. Fever	30. Hip/joint replacement	41. Rheumatic fever	
9. Cancer or tumor	20. Glaucoma	31. HIV/AIDS	42. Shortness of breath	
10. Chemotherapy	21. Heart attack or stroke	32. Kidney trouble	43. Sickle cell anemia	
11. Chest pains	22. Heart condition	33. Liver disease	44. Sickle cell trait	

1. Have you ever received any health-related service from the Marion County Public Health Department.	Yes	No
2. Do you have any diseases, conditions or problems not listed above?	Yes	No
3. Are there any activities in gym class, athletics or other physical activities restricted in any way?	Yes	No
4. Are you presently taking any medicine or drugs? List medication(s), dosage and directions _____ _____ _____	Yes	No
5. Have you ever taken Fen-phen/Redux?	Yes	No
6. Are you now or have you been under the care of a physician during the last two years?	Yes	No
7. Have you ever been hospitalized or had surgery?	Yes	No
8. Are you allergic to latex?	Yes	No
9. Are you allergic to any medicine, drug or other substance? If "yes", please list: _____ _____ _____	Yes	No
10. Have you ever had a reaction to local anesthetic?	Yes	No
11. Have you ever had a prolonged or unusual bleeding?	Yes	No
12. Have you ever had complications or illness following dental treatment?	Yes	No
13. Have you ever had any injury or trauma to your face or jaw?	Yes	No
14. Do you smoke or use smokeless tobacco?	Yes	No
15. Are you nervous or concerned about having dental work done?	Yes	No
16. Women:		
Are you pregnant? Due date: _____	Yes	No
Do you use birth control?	Yes	No
Do you anticipate becoming pregnant?	Yes	No
Have you had any complications or problems with previous pregnancies?	Yes	No
17. Do you presently have a dentist?	Yes	No
Dentist's Name: _____		
Address: _____		
18. Are you having dental pain or discomfort at this time?	Yes	No
19. Why are you seeking dental treatment? _____ _____ _____		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the doctor at the next appointment. Specific dental procedures will be explained to me. I understand that I/my child may not be able to receive all of the desired services from the Marion County Public Health Department and my treatment may require the need for me to be referred to other dental practitioners due to the nature of my dental problem. I understand that all dental procedures have benefits as well as certain risks, including possible side effects from some medicines used in dentistry and that these risks include, but are not limited to allergic reactions, cuts/abrasions, tenderness/bruising from injections, sensitive teeth, swallowing inhaling dental materials/prosthesis and infections or serious complications or conditions.

Patient/Parent/Guardian signature: _____ Date: _____

I also authorize and agree that the Health and Hospital Corporation of Marion County may keep or compile health information in any manner and is hereby authorized to use any treatment records, x-rays or photography for teaching or research purposes, including scientific journals or government-related publications. Patient confidentiality will be protected. Patient's name or other private identifying information will not be released.

Patient/Parent/Guardian signature: _____ Date: _____

I hereby authorize insurance benefits to be paid directly to the dentist or their representative (Health and Hospital Corporation). I also authorize the dentist or other appropriate staff or representative to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. I also agree that the Marion County Public Health Department may release a copy of my medical/dental record, or any portion thereof, or other information to the health professionals involved with my medical/dental care.

Patient/Parent/Guardian signature: _____ Date: _____

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Dear Parent or Guardian:

The Marion County Public Health Department (MCPHD) Smile Mobile will be visiting your child's school soon. The Smile Mobile is a forty foot, fully equipped dental office that comes complete with a reception/education area, a two chair dental treatment area, and a complete lab/sterilization area. The Smile Mobile provides a mobile dental office for all children ages 18 and younger. Our goal is to provide a positive dental experience and an opportunity for better oral and overall health for your child.

The MCPHD Smile Mobile is staffed by a highly qualified, professional and friendly dental team from the Marion County Public Health Department. The safety of your child is assured by ethical standards of practice by staff and dental services that are provided in a safe, sterile and pleasant environment. All dental instruments are sterilized or disposed of after each patient.

The MCPHD Smile Mobile provides dental examinations, x-rays, cleanings, fluoride treatments and dental education during your child's visit. If time allows, dental sealants are also provided. Your child will be encouraged to brush and floss daily to maintain a healthy smile and teeth. After the visit, a dental report from the dentist will be sent home with your child. The report will inform you on what treatment was provided and what further treatment is recommended. You will also receive a MCPHD Dental Services brochure listing MCPHD dental clinics where your child can receive further recommended treatment or you may seek treatment at a dental office of your choice. The dentist will contact you immediately regarding any urgent or emergency recommended treatment.

There is an administration fee of $30 for your child's dental visit. Medicaid and personal insurance reimbursement are also accepted as payment. Please be sure to include your child's Medicaid or your personal insurance information with the attached registration and treatment consent form. If you do not have Medicaid or personal insurance for your child, a mail-in payment request for the $30 fee and a blue, self-addressed, return envelope will be sent home with your child. Money will not be collected at the visit.

If you would like for your child to receive dental services from the MCPHD Smile Mobile, please fill out, in full, the attached form regarding your child's medical history, family physician and a telephone number where you (or other adult family member) can be reached during the school day. Please sign the form and return it to your child's school immediately. Please do not send money with the form or your child.

We look forward to serving your child's dental health needs!

Sincerely,

The MCPHD Smile Mobile Dental Team

* In order for your child to receive services, please answer all questions in ink and return this completed form to your child's school.