THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

give kids a smile!
ADA Foundation

Dear Parent,

We want to know about your child in order to care for them safely. Please complete this form to the best of your ability. One of the GKAS Team dentists will review it before treating your child.

PLEASE PRINT ALL Information Below:

Your Child's Information:

Name _____ Date of Birth _____
Last First MI

Male ☐ Female ☐

Race/Ethnicity (please check one):

White ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ Other ☐

The Legally Responsible Guardian's Information: (Select One)

Father ☐ Mother ☐ Foster Parent ☐ Grandparent ☐

Other ☐ (Relationship) _____

Name _____ Date of Birth _____
Last First MI

Male ☐ Female ☐

☐ Work Phone _____ ☐ Cell/Pager _____
Area Code + Number Area Code + Number

☐ Home Phone _____
Area Code + Number

Home Address _____ _____ _____
Street City ZIP code

** PLEASE CHECK THE PHONE NUMBER YOU CAN IMMEDIATELY BE REACHED AT IN CASE OF EMERGENCY**

Please check the insurance coverage that applies to this patient:

☐ **Public Agency Insurance (Medicaid, Molina, or CareSource)?**

☐ **Private Insurance?**

☐ **No Insurance?**

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

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Authorization/Consent for Photography, Interview, and/or Video Release of Information

I, _____, voluntarily give my permission for information gathered in interviews, photographs, film, or videotape of me to be used by news media, College of Dentistry staff, or their representatives for the communications of events, programs, services, procedures and the like in The Ohio State University and/or College of Dentistry news releases, publications, and web sites. I understand once materials are released to the media or printed or posted, Ohio State's College of Dentistry retains no further control over their use.

I, _____, voluntarily give my permission for dental information regarding my dental condition or treatment to be released to the news media, dental college staff, or their representatives for their use. I understand once materials are released to the media or printed and posted, the College of Dentistry retains no further control over their use.

I understand that this information may no longer be protected by federal privacy rules such as the HIPAA Privacy Rule or other confidentiality protections. I have been offered the opportunity to ask questions, or have this form read to me. I understand that I may revoke this authorization, in writing, at any time to the Marketing and Communications department at the address above. Any revocation will not apply to information that has already been released or used. I also understand that I am not required by The Ohio State University College of Dentistry to agree to the use of or release of information or images described above and that I am not required to sign this form as a condition of treatment.

_____ _____
Participant Signature Date

Please Check: ☐ Staff ☐ Patient or Guardian ☐ Physician ☐ Other

Mailing Address: _____

_____

Daytime Phone Number: (_____) _____