THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

Ohio State Upper Arlington Dentistry
1800 Zollinger Rd., Suite 1200, Columbus, OH 43221
Phone: 614-366-3400, Fax: 614-366-8510
Email: OSUDental-UA@osu.edu

For Office Use Only: EMR #: _____

Patient Registration

Please complete registration in its entirety. Have your insurance card(s) and driver's license available for scanning purposes.

Mr._____ Mrs._____ Miss_____ Ms._____ Dr._____

Patient Name _____
Last First M.I. Maiden

Preferred Name_____Birth Date_____

_____Male _____Female Patient's Social Security Number_____

Primary Language:_____Do You Need an Interpreter? _____Yes _____No

Marital Status: _____Single _____Married _____Divorced Other_____

Home Address: _____

_____
City State Zip

Home Phone (_____)_____Cell Phone (_____) _____

Work Phone (_____)_____Preferred Contact # _____Home _____Cell _____Work

Email Address_____May We Email You? _____Yes _____No

We utilize EasyMarkit Appointment Reminder System. Appointment reminders are sent out 48 hours prior to scheduled appointments. Please indicate your preference for reminder:

Text_____ Phone Call/Voicemail_____ Email_____ I prefer not to be contacted_____

Student: _____Yes _____No Where?_____ _____Full Time _____Part Time

Patient's Employer_____ May you be contacted at work? _____Yes _____No

Patient's Profession _____

EMERGENCY CONTACT/RELATIONSHIP_____

PHONE_____

Primary Care Physician: _____ Phone: _____
First Name, Last Name

Pharmacy Name_____Zip Code: _____ Phone: _____

Do you have family members who are patients of our practice? _____Yes _____No

If yes, name of patient(s) _____

_____

Patient Signature: _____**Date**:_____
If patient is a minor, parent's signature

Whom may we thank for referring you to our office?

_____Referred by Dentist or Physician _Advertisement _____Internet/Website _ __Family Member/Friend

_ _OSU Employee Benefit Fair _____Other, please explain _____

Referral's Name (person or advertisement source)_____

Child Medical History

Patient Name: _____ Date of Birth _____ Today's Date _____
First M.I. Last.

Please mark YES or NO

Y	N	GENERAL
		Height _____ft_____in
		Weight _____lbs
		General health status (choose one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐	☐	Is your child/adolescent under a physician's care?
☐	☐	Has your child/adolescent ever been hospitalized?
☐	☐	Has your child/adolescent had any emergency room visits?
☐	☐	Has a doctor limited activities for your child/Adolescent?
☐	☐	Can your child/adolescent climb two flights of stairs without resting?

Please answer "yes" or "no" for any conditions that you have now, or have had in the past

Y	N	CARDIOVASCULAR / HEMATOLOGIC
☐	☐	Does your child/adolescent have any heart or blood conditions?
☐	☐	History of heart problems or heart murmur
☐	☐	Bleeding or clotting conditions
☐	☐	Sickle cell anemia or trait

Y	N	PULMONARY / BREATHING
☐	☐	Does your child/adolescent have any lung or breathing conditions?
☐	☐	Seasonal stress or exercise induced allergies or hay fever
☐	☐	Asthma or wheezing
☐	☐	Snoring, interrupted breathing, sleep apnea
☐	☐	Other lung or breathing conditions

Y	N	HEAD / EYES / EARS / NOSE / THROAT
☐	☐	Does your child/adolescent have any head, eye, ear, nose, or throat conditions?
☐	☐	Frequent sinus infections (sinusitis)
☐	☐	Frequent ear or hearing problems
☐	☐	Vision conditions
☐	☐	Frequent sore throat

Y	N	NERVOUS SYSTEM
☐	☐	Does your child/adolescent have any nervous system conditions?
☐	☐	Epilepsy or seizure disorder - **if yes**, please choose which type: ☐ Absence ☐ Grand mal ☐ Petit mal ☐ Other

Y	N	GASTROINTESTINAL / LIVER / BLOOD / METABOLIC
☐	☐	Does your child/adolescent have any gastrointestinal, liver, blood or metabolic conditions?
☐	☐	Hepatitis or other liver conditions
☐	☐	Diabetes - **if yes**, please choose which type: ☐ **I** ☐ **II**
☐	☐	Thyroid disease
☐	☐	Kidney conditions
☐	☐	Gastrointestinal esophageal reflux disease (GERD)
☐	☐	Other stomach/intestinal conditions

Y	N	INFECTIOUS DISEASES
☐	☐	Does your child/adolescent have any infectious diseases?
☐	☐	Tuberculosis (TB)
☐	☐	HIV positive or AIDS
☐	☐	Fever blisters/mouth sores
☐	☐	Other infectious or immune conditions _____

Y	N	ORTHOPEDIC / MUSCULOSKELETAL
☐	☐	Does your child have any orthopedic or musculoskeletal conditions?
☐	☐	Bone or joint conditions

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Y	N	DEVELOPMENTAL
☐	☐	Does your child/adolescent have any developmental conditions?
☐	☐	Genetic disorder
☐	☐	Cerebral palsy
☐	☐	Cleft lip or palate
☐	☐	Intellectual disability
☐	☐	Speech conditions
☐	☐	Developmental delay
☐	☐	Autism spectrum disorder
☐	☐	ADHD
☐	☐	Prematurity or preterm birth
☐	☐	Other developmental or acquired disability

When was the onset of puberty for your child/adolescent?

(For girls) First period: Month_____Year _____

Y	N	SOCIAL
☐	☐	Does your child/adolescent have any social conditions?
☐	☐	Recreational drug or alcohol use
☐	☐	Smoking or tobacco use

Y	N	OTHER
☐	☐	Does your child/adolescent have any other medical conditions?
☐	☐	Skin conditions
☐	☐	Cancer, cancer treatment **If yes**, what type/location_____
☐	☐	Pregnant or nursing If pregnant, expected delivery date _____
☐	☐	Recent rapid growth
☐	☐	Emotional/behavioral/psychiatric conditions
☐	☐	Does your child/adolescent have any other conditions not listed above?
☐	☐	Does your child/adolescent have any conditions requiring accommodation?

MEDICATIONS AND ALLERGIES

List any current or recent medications you take:

Allergies or reactions to any medicines?

Medication name: _____Reaction: _____

Medication name: _____Reaction: _____

Medication name: _____Reaction: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and my treatment results.

Your signature: _____

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. This would include mailing correspondence to the individual's office instead of the individual's home, emailing correspondence (via secure email server) and/or the use of text messaging systems.

I wish to be contacted in the following manner (check all that apply):

Home Phone (_____)_____

_____O.K. to leave message with detailed information

_____Leave message with callback number only

Cell Phone (_____)_____

_____O.K. to leave message with detailed information

_____Leave message with callback number only

_____O.K. to text appointment information

_____O.K. to text account/financial information

Work Phone (_____)_____

_____O.K. to leave message with detailed information

_____Leave message with callback number only

Written Communication - U.S. Mail/Fax

_____O.K. to mail to my home address

_____O.K. to mail to my work/office address

_____O.K. to fax to number indicated below

Fax # (_____)_____

Written Communication - E-mail (via secure email server)

_____O.K. to email appointment information

_____O.K. to email account/financial information

Email Address:

_____

I hereby grant permission for Ohio State Upper Arlington Dentistry providers and/or representatives to share clinical and financial information with or answer questions from (check all that apply and print name or names):

_____ Spouse_____

_____ Parent_____

_____ Child_____

_____ Other (name and specify relationship):_____

_____ Direct patient contact only

_____ _____

Patient or Guardian Signature | Print Name of Patient or Guardian

Date Signed_____

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