THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

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

College of Dentistry
Marketing and Communication
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Columbus, OH 43210

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614-688-3188 Fax

www.dentistry.osu.edu

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: (__________) ____