TrueSmile Dental Registration Form

Health inside. Welcome in. truecare™

Date: _____

I give permission for my child to receive dental services, and a six-month follow-up. Our dental services include a visual exam, fluoride varnish, and sealant placement (if necessary). If you do not want your child to receive any of the services, you do not need to fill out this form.

Initial Here

If you do not want your child to receive one or more of these services, please list:

☐ N/A ☐ Visual Exam ☐ Fluoride Varnish ☐ Sealant Placement

Child Information

Child's First Name		**Child's Last Name**	**DOB** mm/dd/yy
Child's Age:	**Child's Gender**	**Social Security #**	**Primary Phone Number**
Mailing Address:		**City**	**Zip Code** / **State**
Child's Ethnicity ☐ Hispanic ☐ non-Hispanic ☐ Unknown		**Child's Race (Check all that apply)** ☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Asian ☐ Black or African American ☐ More than one Race ☐ Other	
What County does Child live in? ☐ San Diego ☐ Riverside		**Child's School**	**Child's Grade** / **Child's Teacher**
Emergency Contact Name:	**Emergency Contact Relationship to Child:** Mother / Father Legal Guardian/ Tutor **Other**:		**Emergency Contact Phone #**

Is the child an existing patient of Truecare ☐ Yes ☐ No

Child's Primary Language ☐ English ☐ Spanish ☐ Other:

Parent/Guardian Information

Relationship to Child: *REQUIRED ☐ Mother / Father ☐ Legal Guardian ☐ Tutor ☐ Spouse

Is the Parent/Guardian a Truecare patient ☐ Yes ☐ No

Primary Language ☐ English ☐ Spanish ☐ Other:

Email Address:

In the past 24 months, have you or anyone in your family worked in any type of agriculture (farm work)?

☐ Yes ☐ No

If Yes, Please select one of the options:

☐ **Migrant**, meaning lived away from home or commuted to work in order to work in any type of agricuture Seasonal Farm Worker ALL year long?

☐ **Seasonal**, only worked in agriculture for a few weeks or months out of the year but NOT for the full year.

My family size (the number in my household supported by this income), including myself, is

Household Income, Total Gross **Annual Income**, Before Taxes is $

Mother's First Name of Parent/Guardian:	**Mother's Last Name of Parent/Guardian:**	**DOB** mm/dd/yy
Father's First Name of Parent/Guardian:	**Father's Last Name of Parent/Guardian:**	**DOB** mm/dd/yy
Others, Full Name	**Relationship to Child**	**DOB** mm/dd/yy

Medical and Dental Health

Does the child have health concerns? ☐ Yes ☐ No	If yes,
Does the child have any allergies? ☐ Yes ☐ No	If yes,
Has the child been seen by a dentist in the last six months? ☐ Yes ☐ No	If yes, when: DATE / /
Does the child have a regular dentist? ☐ Yes ☐ No	If yes, where:

Health Coverage

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Does child have insurance coverage? ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS

I authorize my healthcare plan/program to reimburse TrueCare for services the child receives. ☐ Yes ☐ No

Health Plan Name	Member ID	Subscriber Name	Subscriber DOB	Relationship to Patient

I would like information on how my family can obtain healthcare coverage ☐ **Yes** ☐ **No**

Patient Consent to Treat

Please initial beside each item that you have reviewed and understood. The items contained are available on the TrueCare website, www.truecare.org for your reference.

- **I acknowledge that I am aware that I may obtain a copy of the Dental Materials Facts Sheet and Proposition 65 information via the TrueCare website or request for a copy to be made available to me.** ☐ Yes ☐ No
- **NOTICE OF PRIVACY PRACTICES**
  ( ) Initials I may obtain a copy of the Notice of Privacy Practices via the TrueCare website, or a copy was made available to me.
- **CONSENT FOR TREATMENT, REFUSAL OF TREATMENT, and DISCLOSURE OF HEALTH INFORMATION**
  ( ) Initials I, (responsible party or authorized caregiver) authorize TrueCare and its assigned clinical staff to administer and perform all dental treatment, diagnostic, surgical, or other services deemed advisable or necessary for dental care. I understand that I have the right to refuse treatment at any time. I can do so by signing a *REFUSAL OF TREATMENT* form. I also give consent to use and disclose dental information necessary for treatment and payment and other healthcare operations.
- **CONSENT FOR COMMUNICATION**
  ( ) Initials I, (responsible party or authorized caregiver) authorize TrueCare and its clinical staff and any affiliate or agent of TrueCare to contact me or others identified below as a member of my health support group on our cell phones and/or home phones, using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, or other computer assisted technology. I understand that my service provider may charge for such calls. I understand that I am not required to consent to such calls or messages as a condition of receiving medical service. If I do not wish to receive communications at the address or phone number above, I will ask a TrueCare staff member to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.
- **PERMISSION TO SHARE HEALTH INFORMATION (Optional)** As your dental care team, we may need to contact you about your health. We would like to invite you to include members of your family and/or others to be part of your health support group. The people you identify below will be permitted to discuss your health information, including but not limited to appointment information, lab results, medication instructions, and referrals information, and they may be contacted for follow-up in case we are unable to reach you. Please provide accurate information for any individuals designated as part of your dental support group. Designated persons must show valid photo ID when in a clinic. **To request a paper copy, please complete the** "Patient Access Request for Health Information Form" **form.**

Name (First/Last)	Date of Birth	Contact Information	Relationship to Child
		Phone #	

Please sign this form to participate. Thank you!

I give permission for my child to take part in this oral health program, and I understand the information on this form. I give permission for dental providers to perform a basic dental screening of my child's teeth. In case of a medical emergency, I give permission to the attending dentist to administer medical treatment including medications as the law permits.

AFFIRMATION OF UNDERSTANDING

My signature below confirms my understanding of TrueCare Consent to Treat/Dental School Program:

Parent or Legal Guardian Signature: _____ **Date:** _____

Relationship to Child: _____

Questions about this form? Please call (760) 736-6767 for help.