Child Health History and Consent for Dental Treatment

Please complete this form and sign as a parent or guardian.

IF YOU DO NOT WANT YOUR CHILD TO RECEIVE DENTAL CARE, DO NOT FILL OUT THIS FORM.

By completing this form, you hereby give permission to TeamSmile to provide free dental care and preventative care including, but not limited to, diagnostic exams, x-rays, professional cleanings, sealants, fillings, extractions, pulpotomies, crowns, while educating your child on the value of a life-long commitment to oral health care.
IF THIS FORM IS NOT COMPLETELY FILLED OUT, NO DENTAL CARE WILL BE RENDERED.

Information About Your Child To Be Completed by Parent or Guardian

Organization Child is With____

Child's Name: ____

Child's Date of Birth: _______________________ **Child's Gender:** Male ____ Female______

Home Address____

City:_________________________________**State**________**ZIP**________________________

Name of Parent/Guardian:_________________________________ **Phone** ______________________

By checking each box, you agree to the following statement:

- ☐ *To the best of my knowledge, the medical history questions on page 2 have been answered correctly and accurately for them to participate.*
- ☐ *I give permission for my child to receive preventative care to help prevent and diagnose tooth decay and gum disease which may include, but is not limited to, x-rays, dental cleaning, fluoride and/or sealants (sealants cover the chewing part of the tooth to provide extra protection.)*
- ☐ ***I give permission for my child to receive local anesthetic (numbing of the teeth) and dental treatment which may include, but is not limited to, extractions, fillings, stainless steel crowns and pulpotomies (baby tooth root canals), all performed by a TeamSmile dentist.***
- ☐ *I permit my child to be photographed while at the program, understanding that the photos may be used in future educational material, social media or on the TeamSmile website.*
- ☐ *I consent to my child participating in face painting and crossfit activities while at the program.*

Person to contact on the day of service at the program:

1. Name: ____
   Phone: ________________________
2. Name: ____
   Phone: ________________________

TeamSmile's mission is to provide your child free dental and preventative care. By signing below, you agree to NOT hold TeamSmile liable for completing the dental care your child is diagnosed and treatment plan that needs to be rendered according to your child's professional evaluation.

Name of Parent/Guardian (Printed) ____

Signature ____ **Date** _________________

Our dental clinic will honor the rights of patients regarding their child's protected health information under the HIPAA Privacy Act with rare exceptions in which TeamSmile must use and disclose only as much information needed to accomplish the intended dental treatment.

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Is your child under a physician's care now? ○ Yes ○ No If yes, explain______________________________________

Has your child been hospitalized ? ○ Yes ○ No If yes, explain______________________________________

Has your child had a major operation? ○ Yes ○ No If yes, explain______________________________________

Has your child had a serious neck or head injury? ○ Yes ○ No If yes, explain______________________________________

Is your child taking any medications, pills or drugs? ○ Yes ○ No If yes, explain______________________________________I

Is there anything else we should know about the health of your child? List below:

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Is your child allergic to any of the following:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics

□ Other If yes, please explain____

Does your child have, or have they had, any of the following?

□ AIDS/HIV Positive	□ Chest Pains	□ Frequent Headaches	□ Irregular heartbeat	□ Scarlet Fever
□ Anemia	□ Cold/Sores/Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ Angina	□ Congenital Heart Disorder	□ Hay Fever	□ Leukemia	□ Sickle Cell Disease
□ Artificial Heart Valve	□ Convulsions	□ Heart Attack	□ Liver Disease	□ Sinus Trouble
□ Artificial Joint	□ Cortisone Medicine	□ Heart Murmur	□ Low Blood Pressure	□ Spina Bifida
□ Asthma	□ Diabetes	□ Heart Pace Maker	□ Lung Disease	□ Stomach/Intestinal Disease
□ Blood Disease	□ Epilepsy or Seizures	□ Heart Trouble	□ Mitral Valve Prolapse	□ Stroke
□ Blood transfusion	□ Excessive Bleeding	□ Hemophilia	□ Pain in Jaw Joints	□ Swelling of Limbs
□ Breathing Problem	□ Excessive Thirst	□ Hepatitis A	□ Parathyroid disease	□ Thyroid Disease
□ Bruise Easily	□ Fainting Spells/dizziness	□ Hepatitis B or C	□ Psychiatric Care	□ Tonsillitis
□ Cancer	□ Frequent Cough	□ Herpes	□ Radiation Treatments	□ Tuberculosis
□ Chemotherapy	□ Frequent Diarrhea	□ High Blood Pressure	□ Recent Weight Loss	□ Tumors or Growths
□ Hives or Rash	□ Renal Dialysis	□ Ulcers	□ Rheumatic Fever	□ Yellow Jaundice
□ Ear tubes	□ Recurrent ear infections	□ Hearing loss		

Has your child ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain:______________________

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To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform TeamSmile of any changes to my child's medical status.

Signature of Parent/Guardian______________________________________**Date:**______________________