

School Dental Program Consent and Medical History Form

Child's Name: _____ Date of Birth: __/__/____ Male Female

(First) (Last)

Home address _____ Town _____ Phone# _____

School _____ Grade _____ Room _____ Teacher _____

YES, I give permission for my child to participate in the North Attleboro Schools Preventive Dental Program
Please complete and return this form.

NO, I do **NOT** give permission for my child to participate in the North Attleboro Schools Preventive Dental

General Information:

1. What language does *your child* speak best? _____ What language does *parent* speak at home? _____

2. What is *your child's* race?

American Indian/Alaskan Native Asian Black/African American Hispanic/Latino White Other

Health Information:

1. Does your child see a doctor for regular checkups? YES NO

2. Does your child see a dentist for regular checkups? YES NO

If yes, name and town of the dentist _____

3. In general, how would you describe the health of your child's teeth and mouth? Excellent Good Poor

4. Is your child taking any medication now? YES NO

If yes, please list medications. _____

5. Has a dentist or physician ever told you that your child needs to take antibiotics before having dental treatment? YES NO

6. Please check any illnesses or conditions your child has EVER had:

ADD/ADHD Diabetes Hepatitis Rheumatic Fever Convulsions
 Anemia Epilepsy Heart Murmur Seizures Allergies to Medicine
 Asthma Heart Conditions Kidney/Liver Tuberculosis

7. Does your child have any other health conditions? YES NO

If yes, please list. _____

8. Does your child have any allergies? *If yes*, please check all that apply: YES NO

Penicillin Antibiotics Colophonium (pine rosin) Aspirin Foods Latex Resins Pine Nuts

Other: _____

9. Does your child have **DENTAL INSURANCE**? YES NO

If your child has dental insurance, please check and complete all that apply below:

| |
|---------------------------------------|
| <u>MassHealth</u> |
| MassHealth RID Number _____ |
| (Located directly under name on card) |
| _____ |

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|---|
| <u>Delta Dental, CMSP, or Other Dental Insurance</u> |
| Insurance _____ |
| Company _____ |
| Address _____ |
| Subscriber _____ |
| Subscriber ID # _____ |
| Subscriber's Date of Birth ____/____/____ |
| Group/Policy # _____ |
| Employer Name _____ |

I understand that Cathy Grinham RDH may use my health information for treatment, payment and health care operations. I have been given a copy of the Notice of Privacy Practices. I have read and understand the dental program and services that may be provided to my child, and I consent to have my child participate in the program. I consent to have my child screened in 6 months and 1 year intervals for sealant retention and fluoride treatment. I authorize the dental program to provide a written summary of the examination/services to an official designated by my child's school. I understand that these services do not substitute for an examination by a dentist. I understand that my child should obtain an examination by a dentist within 90 days, if they have not had one, and if needed, this program will provide a list of dentists in my area. I understand that my child may continue to obtain dental care through any other provider. If I have dental insurance, I acknowledge that this treatment may affect future rights and insurance benefits and I authorize my insurance carrier to be billed for any services provided.

X _____ **Date:** __/__/__ **Relationship to Child:** _____
Parent/Guardian Signature

_____ **Print Name** _____ **Daytime Ph Number** _____ **Cell Ph Number** _____ **Email Address**
(For office Use Only) Reviewed By : _____ **Date** __/__/__