Visiting Dental Hygiene Associates

Pediatric Dental Program Permission and Medical History Form

Child's Name: _____ _____ Date of Birth: _ _/_ _ /_ _ _ _ © Male © Female
(First) (Last)

School _____

Grade_____Room_____Teacher _____

☐ **YES**, I give permission for my child to participate in the preventive school based dental program. I approve billing my insurance company for services provided. ***Please check yes, complete entire form and sign below.***

☐ **NO,** I do **NOT** give permission for my child to participate in this program.

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 of the dentist_____
3. In general, how would you describe the health of your child's teeth and mouth?
   © Excellent © Very Good © Good © Fair © 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 (penicillin) 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 © HIV/AIDS
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 © Aspirin © Foods © Latex © Resins © Other: _____
9. Does your child have **DENTAL INSURANCE**? © YES © NO
   If no, would you like help getting health or dental insurance for your child? © YES © NO

If your child has dental insurance, please check which one and complete below:
© Blue Cross/Shield © Delta Dental © Children's Medical (CMSP) © Mass Health/Medicaid © Other_____

MassHealth

Child's Name on card:_____

Insurance Number (RID)- 12 digit

_____

Delta Dental, CMSP, or Other Dental Insurance

Company_____

Address_____

Subscriber_____

Subscriber ID #_____

Subscriber's Date of Birth_____/_____/_____

Group/Policy #_____

Employer Name_____

I understand that_____may use my child's health information for treatment, payment and health care operations. I have been given a copy of their Notice of Privacy Practices. I have read and understand the dental program and services that may be provided to my child. I consent to have my child participate in the program. 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 and that my child should obtain an examination by a dentist within 90 days, if they have not had one. If needed, this program will provide a list of dentists in my area. I understand that my child may continue to receive dental care from any other provider. If I have dental insurance, I acknowledge that this treatment may affect my 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