

Visiting Dental Associates of MA Public Schools Dental Program Consent and Medical History Form

Child's Name: _____ Date of Birth: __/__/____ Male Female
 (First) (Last)
 Town _____ School _____
 Grade _____ Room _____ Teacher _____

YES, I give permission for my child to participate in the VDA of MA Middleboro Public Schools dental program.

NO, I do NOT give permission for my child to participate in the VDA of MA Middleboro Public Schools dental 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

MassHealth RID Number

NOTES:

I understand that Cathy Grinham RDH VDA of MA 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

_____ _____ _____ _____
 Print Name Daytime Phone Number Cell Phone Number Email Address