Health History/Consent for Treatment

Office Use

Please complete this form and sign as parent or guardian. This completed form and a reservation is needed to participate. "Give Kids A Smile" provides free, comprehensive dental

Who Referred You/How Did You Hear About Us? (Name of the friend, school, church, organization):
Name:_____
Address:_____
City:_____State:_____ZIP:_____
Email:_____@_____ FAX#:_____
Office Phone:_____

To Be Completed by Parent or Guardian – Information about your child

Child's Name: First_____MI____ Last_____
Child's Date of Birth: _____ Child's Gender: Male ____ Female_____
Home Address_____
Street City Zip Code
Home Phone _____ Cell/Mobile Phone_____

Medicaid Eligible _____Yes _____No

Please check all that apply to the child: **Not listed: _____ ID Number_____**
Medicaid Coverage: ☐ Health Care USA ☐ Molina ☐ Harmony ☐ MO Health Net ☐ MO Care+ (red card)
Medicaid ID: _____ ☐ Free & Reduced Lunch ☐ Partial Free/Reduced Lunch

Name of Parent/Guardian:_____Birth Date_____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Child Lives With: ☐ Check if same as above
Name: First:_____MI_____Last_____
Address:_____
City:_____State_____ZIP_____
Home Phone:_____Cell Phone:_____

IN CASE OF EMERGENCY CONTACT on the day of service at the clinic:
Name: First:_____MI:_____Last:_____
Address:_____
City: _____State: _____ZIP: _____Phone: _____

I give consent for my child to participate in the preventive and restorative dentistry program conducted by the Committee for Community Outreach and Access program, known as Give Kids A Smile. To the best of my knowledge, the medical history questions on page 2 have been answered correctly and accurately. I allow my child to receive local anesthetic (numbing of the teeth), dental treatment, antibiotics and analgesics (Tylenol, Ibuprofen) with appropriate instructions if deemed necessary by the treating dentist, and to be photographed while at the clinic, understanding that the photos may be used in future educational material. Our dental clinic will honor the rights of patients regarding their protected health information with rare exceptions that must use and disclose only as much information needed to accomplish the intended dental treatment.

Name of Parent/Guardian (Printed) _____
Signature _____ Date _____

For reservations call: 636-397-6453 (GKAS) Fax completed consent form to: 1-636-278-2676
Or, mail completed consent form to: GKAS, 340-A Mid Rivers Mall Dr., St. Peters, MO 63376

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, what medication_____

_____

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:_____

_____

_____

_____

_____

_____

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 Give Kids A Smile of any changes to my child's medical status.

Signature of Parent/Guardian_____**Date:**_____