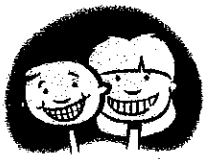
Healthy Smiles, Happy Kids
Mobile Dental Van



CONSENT FOR DENTAL TREATMENT

Please Print and Complete this Form in INK

This Consent form and the Patient Information and Health History must be returned before dental services will be scheduled for your child. A new consent and health history must be completed for all patients (new or existing) enrolled in dental van program. A written report of services provided will be sent home with your child following each appointment on the Mobile Dental Van. **If you have any questions , please call:** Dr. Sheila A. Smith, DMD or Karen Kroboth, RDH, CDA at (610) 377-7354.

I authorize the dental staff to provide dental services for my child. Routine treatment will include an examination by a licensed dental professional and may include x-rays, cleaning, sealants, topical fluoride, injection of a numbing agent (local anesthesia) and dental fillings. I understand that the risks of dental treatment are uncommon but could occur. These risks include: infection, continued numbness or tissue irritation from local anesthetic, inhalation of a foreign body, accidental cut, soreness, pain, swelling, and allergic reaction to numbing agent. **I understand that it is my responsibility to notify the Dental Staff of any changes in my child's health, medications or insurance coverage and that I may withdraw consent at any time.**

I authorize the dental staff to bill my insurance provider for services rendered. For dental services provided to MA recipients the payment and satisfaction of the claim submitted by the provider of the services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material facts may be prosecuted under applicable Federal and State laws.

Medical Assistance Coverage:

___ Access Plus ID # _____ Card issue # _____

___ Gateway ID # _____

___ United Concordia CHIP ID # _____

___ Ameri-Health Mercy ID # _____

___ Aetna CHIP ID # _____

___ Geissinger CHIP ID # _____

___ UnitedHealth Care ID # _____

___ UnitedHealth Care CHIP ID # _____

I have had the opportunity to ask questions about the above information, clinic procedure and treatment and these questions have been answered to my satisfaction.

Full Name of Child **(please print)** _____

Child's Date of Birth _____ Social Security Number _____

Full Name of Parent/Legal Guardian **(please print)** _____

Parent/Legal Guardian **SIGNATURE** _____ **DATE** _____

Please check one of the following: existing dental van patient _____ **new patient** _____

(TURN FORM OVER TO COMPLETE HEALTH HISTORY)

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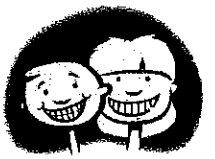

PATIENT INFORMATION AND HEALTH HISTORY

Please Print and Complete this Form in INK

PERSONAL Information

Patients Full Name _____ Sex _____ Child's School _____

Address _____ School District _____ Grade _____

City _____ State: _____ Zip _____ Date of Birth ____/____/____ Social Security # _____

Parents/Guardian _____ E-mail _____

Home Phone _____ Work Phone _____ Cell phone _____

Emergency Contact _____ Relationship _____ Phone# _____

DENTAL History

Has your child ever been to a dentist before? ____ Yes ____ No
When was your child's last check-up and cleaning? _____ X-Rays? _____
What was your child's previous dentist's name and address _____
Were there any special problems associated with any previous dental visits? If yes, then what? _____
What is your child's attitude toward the dentist ____ frightened ____ nervous ____ neutral

MEDICAL History

		Y	N
1.	Is your child presently in good health?	___	___
2.	Is your child presently under a physician's care?	___	___
	a. If yes, why? _____	___	___
3.	Is your child presently taking any Medicines?	___	___
	a. If yes, what? _____		
4.	Does your child have any allergies to:		
	a. Antibiotics (please list) _____		
	b. Aspirin	___	___
	c. Codeine	___	___
	d. Latex	___	___
	e. Dairy	___	___
	f. Seasonal (pollen, etc.)	___	___
5.	Has your child ever experienced an unfavorable reaction to medicine? If yes, what? _____		
6.	Does your child have/had a heart murmur, rheumatic fever, or a shunt? (please circle which one) Is antibiotic coverage needed for dental?	___	___
7.	Does your child have any specific medical condition? (cancer, cerebral palsy, mental retardation, etc.) _____		
8.	Has your child ever had a history of:		
	a. Asthma	___	___
	b. Hepatitis (A, B or C)	___	___
	c. HIV/AIDS	___	___
	d. Diabetes (type I or II)	___	___
	e. Kidney or liver disease	___	___
	f. Tuberculosis	___	___
	g. Bleeding disorders	___	___
	h. Anemia	___	___
	i. Chicken pox	___	___
	j. Measles	___	___
	k. Seizures	___	___
	l. High blood pressure	___	___
	m. Speech problems	___	___
	n. Learning disabilities (ADHD, ADD, etc.)	___	___
9.	Has your child ever had bleeding gums?	___	___
10.	Does your child have a history of:		
	a. Thumb/finger sucking	___	___
	b. Mouth breathing	___	___
	c. Grinding teeth	___	___
11.	Does your child take dietary fluoride? (tablets or drops)	___	___
12.	Does anyone in the household smoke?	___	___
13.	Is there any other information which you think we should know: _____ _____		
14.	Do you have any special concerns about your child's mouth?		
	a. if yes, what? _____		

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.

Full Name of Child (**please print**) _____

Full Name of Parent/Legal Guardian (**please print**) _____

Parent/Legal Guardian **SIGNATURE** _____ **DATE** _____

Blue Mountain
HEALTH SYSTEM
Gnaden Huetten Memorial Hospital - Palmerton Hospital

Patient Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our privacy officer at 610.377.7063.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our notice of use and disclosure of protected health information about you for treatment, payment and health care operations.

Signature:_____

Date:_____

Please Print Name:_____

A copy of the Notice of Privacy Practices can be viewed at www.blmtn.org/contents/privacystatement.htm