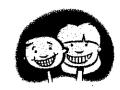
## Healthy Smiles, Happy Kids Mobile Dental Van



### 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 <u>all patients</u> (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.

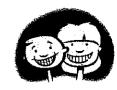
I authorize the dental staff to provide dental services for my child. Routine treatment will include an examination by a licensed dental professional and may include x-rays, cleaning, sealants, topical fluoride, injection of a numbing agent (local anesthesia) and dental fillings. I understand that the 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#		<del></del>	
Aetna CHIP	ID#			
Geissinger CHIP				
UnitedHealth Care	ID#		<u></u>	
UnitedHealth Care CHIP	ID#			
I have had the opportunity to ask of answered to my satisfaction.	questions about th	he above information, clinic pr	ocedure and treatment and the	se questions have been
Full Name of Child (please print)	·			_
Child's Date of Birth		Social Security Number		-
Full Name of Parent/Legal Guard	an (please print)	)		-
Parent/Legal Guardian SIGNATU	IRE		DATE	-
Please check one of the following	z: existing denta	al van patient ne	ew patient	

(TURN FORM OVER TO COMPLETE HEALTH HISTORY)

# Healthy Smiles, Happy Kids Mobile Dental Van



## PATIENT INFORMATION AND HEALTH HISTORY

#### Please Print and Complete this Form in INK

prents/Guardian	tients Full Name			Sex	Chil	ld's Sch	nool	
mergency Contact Relationship Phone#  DENTAL History as your child's last check-up and cleaning? Yes No hen was your child's last check-up and cleaning? Nat was your child's previous dentist's name and address (ret ret rea my special problems associated with any previous dental visits? If yes, then what?  It is your child's attitude toward the dentist frightened nervous neutral  MEDICAL History  Y N  I. Is your child presently in good health? Y N  I. Is your child presently under a physician's care? C. Kidney or liver disease for the previous dentist in the previous denti	.ddress		School District				Grade	
DENTAL History  Is 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 dential visits? If yes, then what? What is your child resembly under a physician's care? nervous neutral  MEDICAL History  1. Is your child presently in good health? 2. Is your child presently under a physician's care? f. Tuberculosis Bleeding disorders f. Tuberculosis Bleeding disorders f. Tuberculosis Bleeding disorders f. Annenia f. Chicken pox f. Annenia f. Chicke	City	State:	Zip	Date of Birth	/_	!	Social Security #	
Jas 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 satitude toward the dentist frightened nervous neutral  MEDICAL History  1. Is your child presently in good health? 2. Is your child presently under a physician's care? 4. Is your child presently taking any Medicines? 5. Is your child presently taking any Medicines? 6. Anibiotics (please list) 7. Does your child have any allergies to: 7. Anibiotics (please list) 8. Aspirin 9. Codeine 9. Has your child ever experienced an unfavorable reaction to medicine? If yes, what? 9. Has your child ever experienced an unfavorable reaction to medicine? If yes, what? 9. Has your child have any specific medical condition? 1. Condense needed for dental? 1. Does your child have any specific medical condition? 1. Condense needed for dental? 1. Does your child have any specific medical condition? 1. Condense needed for dental? 1. Does anyone in the household smoke? 1. Does your child have any specific medical condition? 1. Condense needed for dental? 1. Does anyone in the household smoke?	Parents/Guardian		· · · · · · · · · · · · · · · · · · ·	E-mail _				
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As 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 by second with any previous dental visits? If yes, then what? What is your child presently in good health?  1. Is your child presently in good health? 2. Is your child presently under a physician's care? 3. Is your child presently taking any Medicines? 4. Does your child hea any allergies to: 5. Aspirin 6. Codeine 7. Codeine 8. Aspirin 9. Learning disabilities (ADHD, ADD, etc.)  5. Has your child ever experienced an unfavorable reaction to medicine?? If yes, what?  6. Does your child have any slergific medical condition? 6. Does your child have any specific medical condition? 6. Does your child have any specific medical condition? 6. Does your child have any specific medical condition? 6. Has your child ever rade a history of: 7. Does your child have any specific medical condition? 7. Does your child have any specific medical condition? 8. Has your child ever had a history of: 9. Has your child ever phase medical condition? 10. Does your child have any specific medical condition? 11. Is pour child ever had a history of: 12. Does your child have any specific medical condition? 13. Is there any other information which you think we should kno if yes, what? 14. Do you have any special concerns about your child's mouth? 15. Does your child the tower had a history of: 16. Does your child have any special concerns about your child's mouth? 16. Does your child have any special concerns about your child's mouth? 17. Does your child have any special concerns about your child's mouth? 18. Has your child ever had a history of: 19. Does your child have any special concerns about your child's mouth? 19. Does your child have any special concerns about your child's mouth? 19. Does your child have any special concerns about your child's mouth? 19. Doe	Emergency Contact		Relation	nship			Phone#	
When was your child's last check-up and cleaning?	DENTAL History							
1. Is your child presently in good health? 2. Is your child presently under a physician's care? 3. Is your child presently taking any Medicines? 4. Does your child have any allergies to: 5. Antibiotics (please list) 6. Aspirin 7. Codeine 7. Codeine 8. Has your child ever experienced an unfavorable reaction to medicine? If yes, what?  7. Does your child have any specific medical condition? 6. Concer goes your child have any specific medical condition? 6. Concer goes your child have any specific medical condition? 6. Concer, or a shunt? (please circle which one) 6. Has your child ever had a history of: 6. Does your child have any specific medical condition? 6. Concer, cerebral palsy, mental retardation, etc.)  8. Has your child ever had a history of: 6. Does your child have any specific medical condition? 6. Concer, cerebral palsy, mental retardation, etc.)  8. Has your child ever had a history of: 6. Diabetes (type I or II)  TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORREC	/hen was your child's last check- /hat was your child's previous de /ere there any special problems as	up and cleaning? ntist's name and ssociated with ar	address y previous den	tal visits? If yes,	hen what?			
1. Is your child presently in good health? 2. Is your child presently under a physician's care?  a. If yes, why?  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 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)  c. Kidney or liver disease f. Tuberculosis g. Bleeding disorders h. Anemia i. Chicken pox j. Measles k. Seizures l. High blood pressure n. 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 kno a. if yes, what?  14. Do you have any special concerns about your child's mouth? a. if yes, what?  15. Has your child ever had a history of: a. Thumb/finger sucking b. Mouth breathing c. Grinding teeth 16. Does your child take dietary fluoride? (tablets or drops) 17. Does your child take dietary fluoride? (tablets or drops) 18. Is there any other information which you think we should kno a. if yes, what?  19. Does anyone in the household smoke? 19. Does your child take dietary fluoride? (tablets or drops) 19. Does your child take dietary fluoride? (tablets or drops) 19. Does your child take dietary fluoride? (tablets or drops) 19. Does your child take dietary fluoride? (tablets or drops) 19. Does your child take dietary fluoride? (tablets or drops) 19. Does your child take dietary fluoride? (tablets or drops) 19. Does your child take dietary fl	MEDICAL History		v	N				
TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORREC	<ol> <li>Is your child presently ur         <ul> <li>a. If yes, why?</li> <li>3. Is your child presently ta</li></ul></li></ol>	king any Medici vallergies to: ease list)  an, etc.) rienced an unfaves, what? d a heart murmucircle which one ded for dental? specific medica ental retardation history of: or C)	orable r, rheumatic c)	e. f. f. g. h. i. j. k. l. m. n. 9. Has y 10. Doe a. b. c. c. c. (tak 12. Doe 13. Is the second seco	Tubercu Bleedin Anemia Chicker Measles Seizure: High ble Speech Learnin Your child s your chi Thumb/fin Mouth bre Grinding to s your chi olets or dro s anyone i ere any ot	ulosis g disord n pox s s s ood pre probler g disab ever ha ld have ager suc athing eeth ld take ops) in the he her info	ders  ssure  ns ilities (ADHD, ADD, etc.)  d bleeding gums? a history of: king  dietary fluoride?  puschold smoke?  prmation which you think we s  cial concerns about your child'	s mouth?
	то тне в	EST OF MY K						CORRECT.
'ull Name of Parent/Legal Guardian (please print)								



#### **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:	···········		·	 <del></del>
Date:				 
Please Print Name:		· · · · · · · · · · · · · · · · · · ·		 

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

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