



Health History/Consent for Treatment



Office Use

Your Appointment Date:

Your Appointment Time:

Who Referred You/How Did You Hear About Us? (Identify 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:

Medicaid Coverage: Health Care USA Molina Harmony Bridgeport MC+ (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, explain_____

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?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold/Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/dizziness | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> 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:** _____