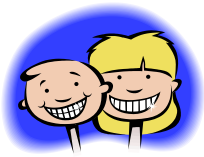
RETURN TO SCHOOL NURSE



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 at **(610)377-7354** or **(484) 464-5656**.

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, documents, or concealment of material facts may be prosecuted under applicable Federal and State laws.

Medical Assistance Coverage:

___ Geisinger ID # _____

___ Ameri-Health ID # _____

___ Aetna Better Health ID # _____

___ My child is covered under private insurance **in addition to** Medical Assistance coverage

Insurance Co. Name_____ Policy #_____

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**) _____ Date of Birth: _____

Child's Social Security Number: _____ Existing dental van patient: _____ New Patient _____

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

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

Notice of Privacy Practices
Patient Acknowledgement Form

Our Notice of Privacy provides information about how we 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 or viewing a copy of the Notice of Privacy Practices at www.blmtn.org/contents/privacystatement.htm .

You have the right to request 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 agree with our notice of use and disclosure of protected health information about your childs treatment, payment and health care operations.

Signature:_____ Date:_____

Please Print Name:_____ Relationship:_____

RETURN TO SCHOOL NURSE

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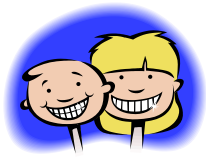

PATIENT INFORMATION AND HEALTH HISTORY

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 _____