Pediatric Dental Program Permission and Medical History Form

Please print in black ink and return to teacher or care provider

Child's Name: ____ Date of birth: _ _ / _ _ / _ _ _ _ ☐ Male ☐ Female
(First) (M.I.) (Last) (mo. / day / year)

Grade: _______ Room #: ___________ Teacher: ______________________ School: ___________________________

Home Address: ____ City: ____________________ Zip: ____________

Parent's Email: ____ *GO TO: masshealthysmiles.com for form in other languages*

☐ **YES**, by completing this form I give permission for my child to participate in the preventive school based dental program. I approve billing my insurance company for services provided. *Please check YES, complete entire form and sign below.*

☐ **NO,** I do not want my child to participate in this program. *Please complete name and grade only.*

General Information:

1. What language does your *child* speak best? _______________ What language is spoken at home? __________________
2. What is your *child's* race?
   ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ More than One ☐ Other ___________

Health Information:

3. Does your child see a doctor for regular checkups? ☐ YES ☐ NO **If yes,** please name ____________________________
4. Does your child see a dentist for regular checkups? ☐ YES ☐ NO **If yes,** please name ____________________________
5. In general, how would you describe the health of your child's teeth and mouth? Date last dental visit________________
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6. Is your child taking any medication now? ☐ YES ☐ NO **If yes,** please list:___________________________________
7. Has a dentist/doctor ever said your child needs antibiotics (penicillin) before dental treatment? ☐ YES ☐ NO
8. Please check any illnesses or conditions your child has EVER had:

☐ ADD/ADHD	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever	☐ Convulsions
☐ Anemia	☐ Epilepsy	☐ Heart Murmur	☐ Seizures	☐ Allergies to Medicine
☐ Asthma	☐ Heart Conditions	☐ Kidney/Liver	☐ Tuberculosis	☐ HIV/AIDS

9. Does your child have any other health conditions? ☐ YES ☐ NO **If yes,** please list: ___________________________
10. Does your child have allergies? ☐ YES ☐ NO **If yes**, please check all that apply or explain: _______________________
    ☐ Antibiotics ☐ Penicillin ☐ Colophonium ☐ Aspirin ☐ Latex ☐ Resin/Rosin ☐ Food/Other:______________________
11. Does child have dental insurance? ☐ YES ☐ NO **If yes** complete below **If no**, would you like help getting it? ☐ YES ☐ NO

MassHealth Patient Information (only)

Child's Name on card: __________________________

Insurance Number (RID) – 12 digit

#____

Dental Insurance Company Information (not MassHealth)

Company: _____________________________________

Address: _____________________________________

Subscriber: ___________________________________

Subscriber ID # _______________________________

Subscriber Date-of-Birth (mo/dy/year) ____/ ____ / ______

Group/ Policy # _______________________________

Employer Name: _______________________________

I understand that MASS Healthy Smiles LLC may use this health information for treatment, payment, and health care operations. I have received Right to Privacy and Program information. I have read and understand the dental program and services that may be provided to my child and consent that my child participates in this program. I understand that these services do not substitute for an examination by a dentist. I understand that my child should obtain an examination by a dentist within 90 days. I understand that my child may continue to obtain dental care through any other provider. I authorize the dental program to provide a written summary of services provided to a designated school official and to forward any referrals to my child's dentist of record when applicable. I understand that the program will provide a list of dentists in my area and will assist in finding a dentist if needed. If I have dental insurance, I authorize my insurance carrier to be billed for services provided. I understand that this treatment may affect future rights and benefits.

X____ Date______ / _____/ _______ Relation to Child: ____________________
Parent/guardian signature (mo / day / year)

Print name: ___________________________ Day Tel# ______________________ Mobile#________________________

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