PREMIER Community HealthCare
YOUR HEALTH. OUR MISSION.

# SCHOOL- BASED DENTAL PROGRAM
## Dental Consent and Medical History

1. **Dental Exam**
2. **X-rays**
3. **Teeth Cleaning**
4. **Fluoride Application** *(cavity prevention)*
5. **Sealants** *(on adult molars)*
6. **SDF** *(Silver Diamine Fluoride)*
7. **Dental Referrals** *(as needed)*
8. **Teledentistry**

The Premier Community HealthCare Mobile Dental Program provides dental care at your child's school during school hours. Dental treatment is provided as needed by a licensed Dentist and/or Dental Hygenist. The treatment will be carried out by a licensed dentist and/or dental hygienist. Local anesthetic (tooth numbing medicine) may be used for some extraction/filling procedures. If you would like for your child to receive services, please complete this form and return to the school. If your child does not have dental insurance or if you have any questions about the program, please contact our Mobile Program Coordinator at **352-518-2000 Ext. 9752.**

## WOULD YOU LIKE YOUR CHILD TO RECEIVE DENTAL SERVICES ON MOBILE UNIT?

☐ **YES**, I give permission for my child to receive preventative dental services.

☐ **NO**, I do not give permission for my child to receive dental services.

If you checked YES, please complete the information below: PLEASE PRINT CLEARLY IN INK

Student's Last Name:_____

Student's First Name:_____

Birth Date:_____/_____/_____ Age:_____

Male ☐ Female ☐ Grade Classroom No:_____

Email:_____

Address:_____

Address Continued:_____City:_____ Zip Code: _____

Parent/Guardian First and Last Name:_____

Birth Date:_____/_____/_____ Relationship to Student/Patient:_____

Home/Cell Phone Number (____)_____ Work Phone Number (____)_____

Name of Emergency Contact:_____

Home/Cell Phone Number (____)_____ Do you have internet access ☐ Yes ☐ No

☐ Black/African American
☐ American Indian/ Alaskan Native
☐ Asian
☐ White
☐ Non-Hispanic
☐ Hispanic/Latino
☐ Native Hawaiian
☐ Pacific Islander
☐ More than 1 race
☐ Decline to Answer

***(Please see back of this form for more information)***

## INSURANCE INFORMATION

☐ Child has MEDICAID: Enter Child's 9 or 10 digit Medicaid Recipient ID Number:

_____

☐ Child has Healthy Kids

☐ Child does not have dental insurance

☐ Child has Private Dental Insurance (for those with private insurance, Parent/Guardian is responsible for deductibles and co-pays.)

Insurance Plan: _____

Insurance ID#:_____Group #_____

Subscriber's Name (parent/guardian):

_____

Subscriber's Birth Date: _____/_____/_____

## MEDICAL HISTORY

When was your child's last dental visit? ☐ Within the last 6 months ☐ More than 6 months ☐ Never been to a dentist

What services has your child received during the last visit?_____

If your child goes to a dentist, please provide name and phone number:

_____ (_____)_____

My child's dental visits have been a good experience. ☐ Yes ☐ No

Recent dental problems ☐ Yes ☐ No

Does your child have Asthma? ☐ Yes ☐ No

Does your child have learning or emotional impairment? ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

ADHD/ADD ☐ Yes ☐ No

Blood Disorder/Anemia ☐ Yes ☐ No

Vision Problems ☐ Yes ☐ No

Hearing Problems ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Heart Problems ☐ Yes ☐ No

Allergies (medication, latex, food)? ☐ Yes ☐ No

What is your child allergic to?_____

_____

Taking daily medications? ☐ Yes ☐ No

If yes, name the medication(s), dosage & directions (*i.e. albuterol*):_____

Condition for medication(s) (*i.e. asthma, allergies, ADHD, eczema*):

_____

Are medications at the school? ☐ Yes ☐ No

If not, where are they?_____

Has your child had any serious health conditions not mentioned above? ☐ Yes ☐ No

Describe:_____

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? ☐ Yes ☐ No

Please explain any Yes answer(s):_____

_____

Please provide the name and number of your child's doctor:

_____ (____)_____

1. I am the legal guardian of the child. I have read and understand the information on this form. This form is to obtain my consent for dental treatment for my child. By signing, I give permission for my child to receive dental treatment from the PCHGMDP.

2. I understand that these services can be obtained at the office of my child's dentist rather than at the PCHGMDP and may affect benefits that my child receives from private insurance, a state or federal program, or other third-party provider of dental benefits.

3. I have answered every question above completely and accurately. I will inform PCHGMDP of any change in my child's health and/or medical conditions.

4. I understand that PCHGMDP will bill my child's private insurance or Medicaid if available and that I will be required to provide my insurance information to receive the services.

## Caring for Your Child's Healthy Smile!

***If your child does not have Dental Insurance, please contact our Mobile Program Coordinator at 352-518-2000 Ext. 9752****

**Consent for Treatment - Parent/Guardian Signature:**

**X_____ Date: ____/_____/_____**

**I hereby grant to Premier Community HealthCare the absolute right and permission to use pictures and/or video footage of myself/my child taken for editorial, trade, advertising and any other purpose. With my signature below, I am signing that I understand that there is no payment for any use of the photographs taken. Parent/Guardian Signature:_____ Date: _____/_____/_____**