PATIENT INFORMATION FORM

Patient Name:_____ DOB: _____

School Attending:_____ Grade: _____

Home Address: _____

_____

Parent or Guardian: _____

Parent or Guardian: _____

Home phone:_____ Cell Phone: _____

Email: _____

Please let us know the best way to contact you; call, text or email? Which number should we use:

_____

In Case of Emergency:

Name:_____

Relationship:_____ Phone number: _____

INSURANCE INFORMATION

Please make sure all insurance information is complete. All children are seen regardless of ability to pay; however, any incomplete information can delay treatment.

Name on Card: _____ Birthdate:_____

Name of Insurance: _____

Address of Insurance: _____

Phone Number of ID #_____ Group #_____

SS# of insurance carrier: _____ Employer:_____

TREATMENT CONSENT AND AGREEMENT FORM

I authorize and request the provision for dental treatment for my child _____
(child's name)

This treatment may consist of dental x-rays, diagnosis, topical fluoride application, and other preventative measures as well as restorations (fillings), extractions as recommended by the Traveling Smiles Portable Dentistry Providers. I understand that Traveling Smiles dentists and staff will use restorative treatment and behavior management that is reasonable and necessary.

I,_____, as a legally responsible guardian of,_____,
(print parent/legal guardian name) (print child's name)

give my consent for the dental services I have authorized below.

I have signed my name next to each type of service for which I am granting authorization:

_____ **Dental exam**, including dental x-rays.

_____ **Preventative services:** teeth cleaning, oral hygiene instructions, sealants, fluoride treatment, silver diamine fluoride.

_____ **Restorative Services:** fillings, stainless steel crowns, pulpotomy. Anesthesia is typically used for these procedures.

_____ **Extraction of primary tooth:** removal of primary (baby tooth) that cannot be restored through other treatments. Anesthesia is used for this procedure.

I understand that local anesthetics may be used when deemed appropriate by the Traveling Smiles Dentist in performing the recommended treatment.

I consent that_____who is under the age of eighteen years old may
(print child's name)

participate in the dental services provided by Traveling Smiles and consent that their dentists and other agents and employees may furnish to Miami County Dental Clinic employees all information concerning the child's case history, dental examinations, written reports (and any accompanying photographs) with respect to the dental examination and the exam results.

Are you currently the legal guardian for this child? YES NO

Can you sign for medical treatment? YES NO

Parent/guardian name (Please print) _____

Relationship to child_____

I certify that all the information in this packet is true and complete to the best of my knowledge. I understand that this consent is valid for the current school year. I understand that I may withdraw consent in WRITING at any time.

Signature_____Date_____

Authorization for Release of Protected Health Information

There may be circumstances where we cannot provide treatment for your child and will recommend that he or she be referred to another dentist. It is your responsibility to call the office in which you are referred to so that you can set up an appointment to be seen. We will then forward your child's health information such as treatment plans and x-rays to the office as requested.

By signing this document, you are allowing the Traveling Smiles Portable Dentistry staff to give or receive your child's health care records to/from other health care providers or child agencies to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care provider that the Traveling Smiles staff recommends to further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

Patient's Name_____Social Security Number _____

I hereby authorize:

Traveling Smiles Portable Dentistry
Miami County Dental Clinic
70 Troy Town Drive
Troy, Ohio 45373
Phone: 937-339-8656

To receive from, or release to, the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian (Please print) _____

Parent/legal guardian signature_____Date_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____

Photo Consent and Release

I consent to the use of pictures, video or audio recordings of myself or my child for program promotion, including print, audio, video and web promotion. I also agree that any writing or other material in connection with the Traveling Smiles Portable Dentistry of Miami County Dental Clinic (including any correspondence from our family to Traveling Smiles Portable Dentistry of Miami County Dental Clinic) may be used in promotional materials.

Signature of parent/legal guardian _____

Date_____

DENTAL INFORMATION

Please answer each question **YES or NO** and provide explanations in the spaces provided if necessary.

Is this the patients first dental visit?_____(if no please answer below)

When was patient's last dental visit and what was done? _____

Date of last dental cleaning and fluoride treatment? _____

Previous dental office: _____

Has patient ever had fillings? _____

Does patient have any current dental issues or concerns? _____

_____

MEDICAL INFORMATION

Please answer each question **YES or NO** and provide explanations in the spaces provided if necessary.

Does patient have a current medical condition? _____

Does patient have a condition that requires premedication for treatment? _____

Current Medications: _____

Has the patient had hospitalizations/surgeries? _____

Allergies that we need to be aware of? _____

Does patient have any special needs that we need to accommodate for treatment? _____

_____

Is the patient pregnant or may be pregnant?_____if yes how far along? _____

Does patient have a history of or difficulty with any of the following conditions? (please check any that apply

__Latex allergy
__Heart murmur
__Rheumatic fever
__Fainting or dizziness
__Lung problems
__Anemia (thin blood)
__Liver problems
__Hypertension (high blood pressure)
__Heart Disease
__Kidney Problems
__Diabetes
__Sexually transmitted disease
__Sinus problems
__Stomach problems
__AIDS/ARC/HIV infection
__HIV antibody positive

Explanations or anything else we should know before treatment: _____

_____

_____