**Consent for Treatment**

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 **Great News!!!**

  **Your child can receive the following DENTAL SERVICES at school:**

 Dental Exam and Diagnosis / Dental Cleaning and Fluoride / Dental X-Rays

 Dental Sealants / Oral Hygiene Instruction / Fillings and Restorative Treatment

 Extractions / Possible use of local anesthetic ("Novocaine") for fillings

This is NOT a free dental clinic. Types of payment are discussed on the next page.

Please Check One Box

 YES, I give permission for my child to participate in the school dental clinic. My child does **not** have a regular dentist.

 NO, I do not give permission for my child to participate in the school dental clinic.

 Stop! Don’t fill out this form. Thank you.

 CONTACT INFORMATION:

ALAMANCE COUNTY CHILDREN’S DENTAL

 HEALTH PORTABLE CLINIC

 1914 McKinney Street

 Burlington, NC 27217

 336-570-6415

PATIENT INFORMATION **Please complete all sections.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth: \_\_/\_\_/-\_\_/\_\_/-\_\_/\_\_/\_\_/\_\_ Gender: \_\_\_ Female/ \_\_\_ Male

School Grade (Month/Day/Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child's Race: \_\_ Asian / \_\_American Indian/Alaska Native

Child's First Name Last Name \_\_ Black/African American/ \_\_ Hispanic/ \_\_ Mixed

 \_\_ Native Hawaiian/Pacific Islander/ \_\_ Other/ \_\_ White

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Number Street Apt. City State Zip Code

PARENT/GUARDIAN INFORMATION

Parent or legal guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best phone number to reach parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2ND phone number for parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Circle one: Home, Cell, or Work)

Parent's/guardian’s e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL INFORMATION **Please Check YES or NO to questions in this section.**

Has your child been to the dentist in the past year? **🞏 YES / 🞏 NO**

 If yes, please write the name of the dentist and date of the visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive routine medical checkups? **🞏 YES / 🞏 NO**

Physician's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician's Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have **allergies**? **🞏 YES / 🞏 NO**

 If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child need **antibiotics** before dental treatment? **🞏 YES / 🞏 NO**

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child take medications on a routine basis? **🞏 YES / 🞏 NO**

 If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a developmental disability or Autism? **🞏 YES / 🞏 NO**

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had any of the following?

**🞏 Y / 🞏 N** AIDS/ARC/HIV **🞏 Y / 🞏 N** Asthma **🞏 Y / 🞏 N** Birth Defects

**🞏 Y / 🞏 N** Blood Disorders **🞏 Y / 🞏 N** Cerebral Palsy **🞏 Y / 🞏 N** Congenital Heart Disease

**🞏 Y / 🞏 N** Diabetes **🞏 Y / 🞏 N** Epilepsy/Seizures **🞏 Y / 🞏 N** Fainting Spells

**🞏 Y / 🞏 N** Prosthetic Heart Valve **🞏 Y / 🞏 N** Hepatitis **🞏 Y / 🞏 N** Heart Murmur

**🞏 Y / 🞏 N** Speech/Hearing Problems **🞏 Y / 🞏 N** High Blood Pressure **🞏 Y / 🞏 N** Rheumatic Fever

**🞏 Y / 🞏 N** Kidney Disorder **🞏 Y / 🞏 N** Tuberculosis **🞏 Y / 🞏 N** Artificial Joint Replacement

**🞏 Y / 🞏 N** Emotional/Behavioral Problems **🞏 Y / 🞏 N** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION You do not need to have insurance to participate.**



* If you have dental insurance, dental services will be billed to the insurance company directly.

**🞏 Self-Pay –** Parents of children without dental insurance will need to provide the family’s complete income and **pay for services** based on the family’s income. Contact our office to discuss at 336-570-6415.

**🞏 Dental Insurance** Subscriber’s ID Number or Social Security Number: \_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **🞏 MEDICAID** **ID Number**: \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private Dental Insurance Company Name Subscriber’s Name (First, Middle Initial, Last)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/ - \_\_\_/\_\_\_/ -\_\_\_/\_\_\_/\_\_\_/\_\_\_

Insurance Company Address (City State Zip) Subscriber’s Date of Birth (month / day / year)

( \_\_\_ \_\_\_ \_\_\_)-\_\_\_ \_\_\_ \_\_\_- \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Telephone # Name of Subscriber’s Employer

TREATMENT DETAILS **The dental program is available to all students through 5th grade.**

Services are provided by licensed dentists, licensed hygienists and certified dental assistants. In some cases, dental students may accompany the dental professionals to provide educational and preventive services.

**Some** patientsmay need to be scheduled for further dental treatment or specialty services and will be referred to our office or a dental provider in your community. **Referrals** are dependent upon the extent of the dental disease as well as the behavior of the patient. If your child is referred, **call our office** to schedule an appointment at 336-570-6415.

**Informed consent** indicates your awareness of sufficient information to allow you to make an informed personal choice concerning the patient’s dental treatment. Most patients do not encounter any difficulties with their treatment. In rare instances, a patient may experience some discomfort or pain. If the patient indicates any resistance to the dental procedure, we will discontinue the treatment.

**The Tell-Show-Do** technique is often used to gain the cooperation and confidence of the dental patient. The dental provider explains what they are going to do then shows what they are going to do with instruments on a model. The provider makes every effort to be a partner in care with the patient and family, making the dental visit pleasant and informative.

CONSENT TO PARTICIPATE **Please read and sign below.**

• I understand this consent will stay in effect while my child is in any ABSS Elementary School. Contact the Alamance County Children’s

 Dental Clinic if you move at 336-570-6415.

• At 1st visit, mostpatientswill receive an exam, x-rays, dental cleaning, fluoride, and sealants. If treatment is needed, a treatment plan and
 consent form will be sent home. The consent form has to be signed and returned. When the consent form is returned, a 2ndvisit for

 restorations, extractions, and/or other treatment can be completed. If any treatment is not completed during the school year, please contact

 the office for an appointment at 336-570-6415.

• I understand dental sealants will be placed on my child’s teeth. The sealants may be rechecked and reapplied next year if needed.

• The parent/guardian has the responsibility to tell the dental provider of any changes in their child’s health information.

• I understand my child’s dental health can be discussed with the school nurse or oral health person at the school.

• A copy of the Notice of Privacy Practices is available upon request.

• I understand this program may only use my child’s health information for treatment, payment, health care operations, and program

 evaluation.

• If I have dental insurance, I authorize my insurance plan to pay for any services provided.

**By signing below, I acknowledge I have read, understand and agree with the information about the school dental clinic. My child does not have a regular dentist and I give permission to have my child participate in this dental program.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Child Relationship to the Child Today’s Date**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Legal Guardian Printed Name of Parent or Legal Guardian**