

PATIENT DENTAL HISTORY

Name of previous or current family dentist _____

Date of last exam _____

1. Does your child's gums bleed while brushing or flossing?	Yes	No
2. Are your child's teeth sensitive to hot or cold liquids/foods?	Yes	No
3. Are your child's teeth sensitive to sweet or sour liquids/foods?	Yes	No
4. Does your child feel pain to any of his/her teeth?	Yes	No
5. Does your child have any sores or lumps in or near the mouth?	Yes	No
6. Has your child had any head, neck, or jaw injuries?	Yes	No
7. Has your child experienced any of the following problems in the jaw?		
Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No
8. Does your child have frequent headaches?	Yes	No
9. Does your child clench or grind his/her teeth?	Yes	No
10. Does your child bite his/her lips or cheeks frequently?	Yes	No
11. Have you ever received oral hygiene instructions regarding the care of your child's teeth and gums?	Yes	No
12. Does your child like his/her smile?	Yes	No

I give consent for my child to participate in the Give Kids A Smile Dental program conducted by the Ill/Iowa Dental Societies. In addition, I agree to share my child's dental information with the Oral Health Care Coordinator, the dental offices participating in the program, and possibly with Community Health Care Dental in order for my child to receive the necessary follow-up dental care.

Name of Parent/Guardian (Printed) _____

Signature _____ Date _____

WAIVER AND RELEASE

In consideration of the free dental services received on the date signed below, I, for myself and anyone entitled to claim through me, do hereby waive and release Dr. _____ or any persons acting on their behalf or sponsoring or volunteering at this office from all claims of liability arising out of my acceptance of such free care including but not limited to medical or dental care or advice.

Services being provided today include examination, x-rays (2), cleaning and fluoride. Other services provided today include...

My prompt arrival to my scheduled appointments is mandatory or I will be excused from the program.

The dentists participating in Give Kids A Smile are available to us for this one-time promotion and not on a regular basis. The free screening services provided today do not constitute acceptance of the patient(s) into the dentist's practice. The dentists and their staff participating in Give Kids A Smile are volunteering their time and expertise to make this a positive experience for you and your children.

All patients that are seen will be prioritized and any follow-up treatment services will be handled by appointments made by the oral health care coordinator, with the dentists who are participating in the follow-up program. I consent to any other follow-up treatment services to be provided by a referring dentist or specialist, as part of the follow-up care program and further waive and release any such follow-up dentists or any persons acting on their behalf or sponsoring or volunteering at this office, from all claims of liability arising out of my acceptance of such free care including but not limited to medical or dental care or advice.

I give my permission for a photographer and/or other news media personnel to take pictures of me and/or my child. I understand that these pictures and/or film or interviews may be published in newspapers, may be used on radio, television, internet, and may be shown to community groups.

I hereby authorize the release of all dental/medical records from the Give Kids A Smile Dental program to a referring dentist.

I have read, or had read to me, and understand and agree to all of the above.

Patient Name

Patient's Social Security Number

Parent/Guardian Signature

Date

Please indicate which DENTAL insurance your child has:

_____ Medicaid (also known as Title 19) _____ Hawk-I _____ Kid Care _____ Other (please list below)

Recipient ID number _____