

**Health History/Consent for Treatment Complete Both Sides**

**Must Wear Face Mask to Clinic**

**Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***To Be Completed by Parent or Guardian – Information about your child***

# **Child**’**s Name: First:\_\_\_\_\_\_ \_Tessa\_\_\_\_\_\_\_\_ MI\_\_\_\_\_ Last:\_\_\_ Wright\_\_\_\_\_\_\_\_\_\_\_**

# **Child**’**s Date of Birth: \_\_\_\_\_8/29/2020\_\_\_\_ Child**’**s Gender:** Male **\_\_\_\_** Female**\_\_\_****X\_\_**

**Home Address \_\_\_\_\_1520 Robert Thompson Dr\_\_\_\_\_\_\_Festus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_63028\_\_\_**

**Street City Zip**

## **Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Mobile Phone\_\_\_314-732-5965\_\_\_\_\_**

**Medicaid Eligible** \_\_ **X \_**\_\_Yes  **\_\_**\_\_No \_\_\_\_**Free & Reduced Lunch** **\_**\_\_\_**Qualify by Income**

**Please check all that apply to the child**: **Other Dental Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medicaid Coverage: X Home State** 🗆 **MO Health / WellCare**  🗆 **IL Medicaid** 🗆**United Health Care**

🗆 **Healthy Blue**

**Medicaid 8 Digit DCN or ID Number**:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Parent/Guardian: \_\_\_\_Gena Wright \_\_\_\_ Birth Date\_\_\_11/4/1973\_\_\_\_\_\_\_\_\_\_**

**Gender:** 🗆 Male **X** Female

**Parents email address: \_\_\_\_\_\_\_\_genaw2003@gmail.com\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child Lives With:** **X Parent** 🗆 **Grandparent** 🗆 **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT on the day of service at the clinic:**

Name: First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_\_\_\_\_\_\_\_\_\_Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Zip

Phone Number Day of Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I give consent for my child to participate in the preventive and restorative dentistry program conducted by the Committee for Community Outreach and Access program, known as Give Kids A Smile. To the best of my knowledge, the medical history questions on page 2 have been answered correctly and accurately.* ***I allow my child to receive local anesthetic (numbing of the teeth) Nitrous, dental treatment,******antibiotics and analgesics (Tylenol, Ibuprofen) with appropriate instructions if deemed necessary by the treating dentist.*** *Our dental clinic will honor the rights of patients regarding their protected health information with rare exceptions that must use and disclose only as much information needed to accomplish the intended dental treatment.* ***I also give permission for my child to b****e* ***photographed while at the clinic, understanding that the photos may be used in future educational and promotional material..***

**Name of Parent/Guardian (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For reservations call: 636-397-6453 (GKAS) Fax completed consent form to: 1-314-222-2820**

**Or, mail completed consent form to: GKAS, 10A Worthington Access Dr. Maryland Heights, MO 63043**

**Childs Name: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical History**

Is your child being treated by a physician now? ○ Yes ○ No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been hospitalized? ○ Yes ○ No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had a major operation? ○ Yes ○ No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had a serious neck or head injury? ○ Yes ○ No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any medications, pills or drugs? ○ Yes ○ No If yes, name them:

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

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**Is your child allergic to any of the following:**

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics

□ Other If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have, or have they had, any of the following?**

□ AIDS/HIV Positive □ Chest Pains □ Frequent Headaches □ Irregular heartbeat □ Scarlet Fever

□ Anemia □ Cold/Sores/Fever Blisters □ Genital Herpes □ Kidney Problems □ Shingles

□ Angina □ Congenital Heart Disorder □ Hay Fever □ Leukemia □ Sickle Cell Disease

□ Artificial Heart Valve □ Convulsions □ Heart Attack □ Liver Disease □ Sinus Trouble

□ Artificial Joint □ Cortisone Medicine □ Heart Murmur □ Low Blood Pressure □ Spina Bifida

□ Asthma □ Diabetes □ Heart Pace Maker □ Lung Disease □ Stomach/Intestinal Disease

□ Blood Disease □ Epilepsy or Seizures □ Heart Trouble □ Mitral Valve Prolapse □ Stroke

□ Blood transfusion □ Excessive Bleeding □ Hemophilia □ Pain in Jaw Joints □ Swelling of Limbs

□ Breathing Problem □ Excessive Thirst □ Hepatitis A □ Parathyroid disease □ Thyroid Disease

□ Bruise Easily □ Fainting Spells/dizziness □ Hepatitis B or C □ Psychiatric Care □ Tonsillitis

□ Cancer □ Frequent Cough □ Herpes □ Radiation Treatments □ Tuberculosis

□ Chemotherapy □ Frequent Diarrhea □ High Blood Pressure □ Recent Weight Loss □ Tumors or Growths

□ Hives or Rash □ Renal Dialysis □ Ulcers □ Rheumatic Fever □ Yellow Jaundice

□ Ear tubes □ Recurrent ear infections □ Hearing loss

**Has your child ever had any serious illness not listed above?** ○ Yes ○ No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Covid-19 Disclosure Information:

This patient disclosure form seeks information from you that we must consider before making treatment decisions during this current pandemic. It is important that you disclose any indication of having been exposed to Covid-19 or whether your child or anyone living with him/her have experienced any signs or symptoms associated with this virus.

1. Has your child or anyone living with the child tested positive for Covid-19?
2. Yes\_\_\_\_No\_\_\_\_
3. Has your child or anyone living with the child been tested recently and are awaiting results of the test? Yes\_\_\_\_No \_\_\_
4. Does your child or anyone living with the child felt hot or have a fever in the last 14-21 days? Yes\_\_\_\_No \_\_\_
5. Are your child or anyone living with the child having shortness of breath or other difficulty breathing? Yes\_\_\_\_No \_\_\_
6. Does your child or anyone living with the child have a cough at this time? Yes\_\_\_\_No \_\_\_
7. Does your child or anyone living with the child have any other flu-like symptoms such as stomach upset, headache,

fatigue, runny nose, or sore throat?

Yes \_\_\_ No

5) Have the child or others living with the child been in contact with any confirmed Covid-19 positive patients?

Yes \_\_\_ No \_\_\_

6) Have the child or others living with the child experienced any recent loss of taste or smell?

Yes\_\_\_\_No\_\_\_

7) Have your child or others living with the child traveled in the past 14 days to any regions affected by Covid-19?

Yes\_\_\_\_No\_\_\_\_

8) Does your child have any of the high-risk factors for Covid 19 (heart disease, lung disease, diabetes, autoimmune)?

Yes\_\_\_\_No\_\_\_\_

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Give Kids A Smile of any changes to my child's medical status.

**Signature of Parent/Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_