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:_______________________ **MI**_____ **Last:**_____________________

Child's Date of Birth: ________________ **Child's Gender:** Male ____ Female_____

Home Address ____
Street City Zip

Home Phone ________________________ **Cell/Mobile Phone**________________________

Medicaid Eligible _____Yes _____No ____**Free & Reduced Lunch** ____**Qualify by Income**

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

Medicaid Coverage: ☐ **Home State** ☐ **MO Health / WellCare** ☐ **IL Medicaid** ☐ **United Health Care** ☐ **Healthy Blue**

Medicaid 8 Digit DCN or ID Number: __________________________

Name of Parent/Guardian: _____________________________ **Birth Date**_________________

Gender: ☐ Male ☐ Female

Parents email address: ____

Child Lives With: ☐ **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 be 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, PO Box 712 Saint Peters, MO 63376

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
□ Anemia
□ Angina
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Blood Disease
□ Blood transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Hives or Rash
□ Ear tubes
□ Chest Pains
□ Cold/Sores/Fever Blisters
□ Congenital Heart Disorder
□ Convulsions
□ Cortisone Medicine
□ Diabetes
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Renal Dialysis
□ Recurrent ear infections
□ Frequent Headaches
□ Genital Herpes
□ Hay Fever
□ Heart Attack
□ Heart Murmur
□ Heart Pace Maker
□ Heart Trouble
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ Ulcers
□ Hearing loss
□ Irregular heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse
□ Pain in Jaw Joints
□ Parathyroid disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Rheumatic Fever
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Yellow Jaundice

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:**_______________________