Mass Kidz Healthy Smiles
School Dental Program Permission and Medical History Form
***Please* print clearly in black ink and return to your child's teacher**

Child's Name: _____ Date of birth: _ _/_ _/_ _ _ _ □ Male □ Female
(First) (M.I.) (Last) (month / day / year)

Grade: _____ Room #: _____ Teacher: _____ School: _____

Home Address: _____ City: _____ Zip: _____

Parent's Email: _____ ***PLEASE VISIT: masskidzhealthysmiles.com for more information***

☐ **YES**, I give permission for my child to participate in the preventive school based dental program.
Please bill appropriate insurance company below for services provided. ***Please complete entire form and sign below.***

☐ **NO**, I do **NOT** give permission for my child to participate in the dental program. ***Please complete name and grade only.***

General Information:

1. What language does your *child* speak best? _____ What language is spoken at home? _____
2. What is your *child's* race?
   □ American Indian/Alaskan □ Asian □ Black/African American □ Hispanic/Latino □ White □ Other _____

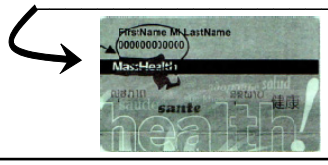
Health Information:

3. Does your child see a doctor for regular checkups? □ YES □ NO **If yes,** please name _____
4. Does your child see a dentist for regular checkups? □ YES □ NO **If yes,** please name _____
5. In general, how would you describe the health of your child's teeth and mouth? Date of last dental visit: _____
   □ Excellent □ Very Good □ Good □ Fair □ Poor
6. Is your child taking any medication now? □ YES □ NO **If yes,** please list: _____
7. Has a dentist/doctor ever said your child needs antibiotics (penicillin) before dental treatment? □ YES □ NO
8. Please check any illnesses or conditions your child has EVER had:

□ ADD/ADHD	□ Diabetes	□ Hepatitis	□ Rheumatic Fever	□ Convulsions
□ Anemia	□ Epilepsy	□ Heart Murmur	□ Seizures	□ Allergies to Medicine
□ Asthma	□ Heart Conditions	□ Kidney/Liver	□ Tuberculosis	□ HIV/AIDS

9. Does your child have any other health conditions? □ YES □ NO **If yes,** please list: _____
10. Does your child have any allergies? □ YES □ NO **If yes**, please check all that apply or explain: _____
    □ Antibiotics □ Penicillin □ Colophonium □ Aspirin □ Latex □ Resin/Rosin □ Food/Other: _____
11. Does your child have dental insurance? □ YES □ NO **If yes,** complete below. **If no**,would you like help getting it? □ YES □ NO

MassHealth Patient Information (MassHealth only)
Child's Name on card: _____
Insurance Number (RID) – 12 digit #: _____



Dental Insurance Company Information (not MassHealth)
Company: _____
Address: _____
Subscriber: _____
Subscriber ID #: _____
Subscriber Date-of-Birth (month/day/year) ____/____/____
Group/Policy #: _____
Employer Name: _____

I understand that Mass Kidz Healthy Smiles, LLC may use this health information for treatment, payment, and health care operations. I have received Right to Privacy and Program information. I have read and understand the dental program and services that may be provided to my child and consent that my child participates in this program. I understand that these services do not substitute for an examination by a dentist. I understand that my child should obtain an examination by a dentist within 90 days. I understand that my child may continue to obtain dental care through any other provider. I authorize the dental program to provide a written summary of services provided to a designated school official and to forward any referrals to my child's dentist of record when applicable. I understand that the program will provide a list of dentists in my area and will provide assistance in finding a dentist if needed. If I have dental insurance, I authorize my insurance carrier to be billed for services provided. I understand that this treatment may affect future rights and insurance benefits.

Sign: _____ Date: _____ Relation to Child: _____
Parent/guardian signature (month/day/year)

Print name: _____ Mobile #: _____ Daytime Telephone #: _____