Child's Name _____

Center _____

CONSENT FOR DENTAL EXAMINATION

I hereby give my consent for my child to have his/her teeth and mouth examined by a dentist, Dr. _____ . I understand that x-rays may be taken and that cleaning and fluoride application may also be done at this appointment.

In order to treat your child, the dentist will need the following information:

1. Has your child previously seen a dentist: ❑ Yes ❑ No
   If yes, Name of Dentist _____ Date of Visit _____
2. List any dental problems that your child has experienced: _____
   _____
3. Does your home have ❑ city water ❑ well water ❑ other _____
4. Does your child have a physician? ❑ Yes ❑ No
   If yes, Name of Physician _____
5. Is your child taking any medications? ❑ Yes ❑ No
   If yes, please list _____

6. Has your child had any of the following:

Allergies	❑ Yes	❑ No	Heart/Vascular Disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
Bleeding	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Sickle Cell Disease	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Other Diseases	_____	

7. Are you aware of any other health problems with your child? _____
   _____

8. Do you have any of the following:
   ❑ Medical Card # _____
   ❑ Private Dental Insurance Company _____ Group # _____
   ❑ Other source of payment for dental care _____

I hereby grant my permission for information on this form to be given to the:
Dentist ❑ Yes ❑ No Health Department ❑ Yes ❑ No

_____ _____
(Date) (Parent or Legal Guardian)

Assurance of Confidentiality: All of the information you provide helps us to deliver services most appropriate for your family needs. You may prefer not to share some information with us. However, some information is required to determined eligibility. All information is held in strict confidence.