ADDITIONAL INFORMATION

Does your child:

◯ Yes ◯ No Need or use more medical care than other children the same age?
◯ Yes ◯ No Have trouble doing things most children the same age can do?
◯ Yes ◯ No Need or get special therapy, such as physical therapy, occupational therapy or speech therapy?
◯ Yes ◯ No Need counseling or treatment for behavior problems, emotional problems or delays in walking, talking or activities other children the same age can do?

If you checked YES to any of the boxes above:

◯ Yes ◯ No Has this problem lasted or is it expected to last at least 12 months?

Household Size	200% FED Threshold
□ 1	$23,760
□ 2	$32,040
□ 3	$40,320
□ 4	$48,600
□ 5	$56,880
□ 6	$65,160

OHP DENTAL CARE CONSENT FORM

Having read the information attached to this form, and having accurately filled out the medical history information, I hereby consent to _________________________________(patient's) participation in the preventative and restorative dentistry program to be conducted by OHP dental staff. The patient has no private dental insurance to cover their treatment.

I understand that, except for in circumstances where in the reasonable discretion of the Dentist, further immediate treatment is necessary to address pain or infection issues or for other reason that in the judgment of the Dentist required immediate treatment, the patient's initial visit will consist of x-rays, diagnostic evaluation, cleaning and sealant placement. In the event that, in the opinion of the treating dentist, immediate treatment is required at the initial visit, I will be contacted at the phone number listed and given a full explanation of the procedures, the risks entailed, the alternative treatment available and the consequences if the treatment was withheld. By this document, I agree to receive that information orally to facilitate the prompt treatment of my child.

I understand that in most circumstances prior to any additional treatment, a consent form will be delivered to me and that I will be required to come to the OHP site for the purpose of receiving an explanation of the procedures that may be undertaken by OHP before those services are delivered.

I understand that if the patient becomes uncooperative during dental procedures with movement of head, arms and/or legs, to the degree that dental treatment cannot be *safely* provided, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements at the direction of the dentist.

I agree to seek any follow-up care my child may need from a local dentist, physician or emergency room. **OHP is not a dental home and does not offer all specialty care.**

I understand that if my child fails to make an appointment or cancels within twenty-four 24 hours, they will not be seen at OHP for a period of one (1) year. I also grant OHP the right to use my child's picture, voice and/or a representation of physical likeness in connection with advertising or publicizing its activities in all forms of media in perpetuity.

In consideration of the dental services to be provided and upon notice as explained in this form, I for myself and the patient and anyone entitled to claim through me or the patient, do hereby waive and release the OHP, the Howe Resource Center, The Green Bay Public School District, the Salvation Army Kroc Center, the Redeemer Lutheran Church and School, paid and volunteered dentists, dental hygienists, dental assistants or any other persons or organizations operating on behalf of OHP or its agents or volunteering services in this program from any and all liability arising from my acceptance of such care, including but not limited to, medical, surgical, dental, or other health care advice, so long as such care is delivered in a manner consistent with reasonably accepted medical/dental services and this agreement.

I have read the foregoing and have had an opportunity to have all my questions answered. In the event that I have any additional questions, I understand that I can get my questions answered prior to executing this form by contacting OHP at **(920) 965-0831**.

I understand that the health information provided herein and this consent can be used for one (1) year and if any change occurs in the patient's health status or if I wish to revoke the consent, I must notify OHP by calling **(920) 965-0831**. I understand that if my child's health information is released according to the HIPAA authorization, it may be subject to re-disclosure by a person who receives the information and may not be protected by law.

I hereby acknowledge and attest that I have the legal authority to consent and authorize to the provision of medical and dental services to patient in the best interests of the patient as stated in this document.

I hereby attest that if my child does not have Medical Assistance, he/she qualifies for free or reduced lunch.

____________ **I have had an opportunity to review/obtain a copy of OHP's HIPPA Privacy Statement. If you are sending this form back to school**
(INITIAL) **with your child and would like a copy of our full privacy policy, please call our office at (920) 965-0831.**

____

PRINT NAME OF PARENT/LEGAL GUARDIAN/PATIENT

____ __________________________

SIGNATURE **DATE**

Child Health/Dental History Form

Child's Name____ ☐ Male
LAST FIRST MIDDLE INITIAL

Date of Birth____ ☐ Female
MONTH/DAY/YEAR

School Attending________________________ Grade______ Height_______ Weight______

Ethnicity (select one)	Race (select one)		
◯ Hispanic	◯ White	◯ Asian	◯ Black/African American
◯ Non-Hispanic	◯ American Indian/Alaskan Native		◯ Native Hawaiian/Pacific Islander
◯ Decline to Specify	◯ Decline to Specify		

Parent/Guardian's Name______________________________ Language spoken by parent______________

Address____
STREET CITY/ZIP

Phone______________________ ______________________ Email______________________________
HOME CELL

Emergency Contact____
NAME PHONE RELATIONSHIP TO PATIENT

◯ **Yes**, I do want my child to participate in school-based dental prevention program and authorize Forward Health to be billed for billable services.

◯ **No**, I don't want my child to participate in the school-based dental prevention program.

Has your child had any history of or conditions related to any of the following?

◯ ADD/ADHD	◯ Chicken Pox	◯ Rheumatic Fever	◯ Mumps	◯ Other
◯ Anemia	◯ Chronic Sinus	◯ Hepatitis	◯ Parasites	________________
◯ Arthritis	◯ Depression/Bi-polar	◯ Herpes	◯ Pregnancy/due date	________________
◯ Asthma	◯ Diabetes	◯ HIV/AIDS	◯ Seizures	**Medical doctor/clinic:**
◯ Autism	◯ Downs Syndrome	◯ Kidney disease	◯ Sickle Cell	***(MUST CHECK ONE)**
◯ Bladder	◯ Ear aches	◯ Latex allergy	◯ Skin disorder	◯ None
◯ Bleeding disorder	◯ Epilepsy	◯ Liver disease	◯ Thyroid	◯ Bellin______________
◯ Bones/Joint	◯ Fainting	◯ Mental disability	◯ Tobacco/drug use	◯ Aurora______________
◯ Cancer	◯ Hearing impaired	◯ Measles	◯ Tuberculosis	◯ Prevea______________
◯ Cerebral Palsy	◯ Heart	◯ Mononucleosis	◯ Venereal disease	◯ Other ______________

Does this patient currently have a dentist?	**Is your child taking any medications?**
◯ Yes ◯ No If so, where:	◯ Yes ◯ No Please List:
What type of Dental insurance does your child have?	**Does your child need pre-medication for a dentist appointment?**
◯ Forward Health/Medicaid/BadgerCare	◯ Yes ◯ No Please List:
◯ Private insurance (i.e. Delta, Cigna)	**Has your child had any other serious illness or operation?**
◯ None ◯ Other	◯ Yes ◯ No Please List:
Does your child qualify for free or reduced lunch?	**Does your child have allergies?**
◯ Yes ◯ No	◯ Yes ◯ No Please List:

How do you prefer to be contacted? ◯ Home Phone ◯ Cell Phone ◯ Email ◯ Text

Continued on side 2 →