OHP Oral Health Partnership
Dentistry for Tots to Teens

Child Health/Dental History Form

Your Child's Information: Today's Date:_____

Date of Birth(MM/DD/YYYY)_____/_____/_____ Gender: ◯ Male ◯ Female

Child's Name_____
LAST FIRST MIDDLE INITIAL

School Attending_____ Grade_____

Ethnicity (select one)
- ◯ Hispanic
- ◯ Non-Hispanic
- ◯ Decline to Specify

Race (check all that applies)
- ◯ White ◯ Asian ◯ Black/African American
- ◯ American Indian/Alaskan Native ◯ Native Hawaiian/Pacific Islander
- ◯ Decline to Specify ◯ Other _____

Child's Dental Insurance: ◯ Forward Health/Medicaid/BadgerCare ◯ Private insurance (i.e. Delta, Cigna)
◯ None ◯ Other

Does your child qualify for free or reduced lunch? ◯ Yes ◯ No

Does your child have a dentist? ◯ Yes ◯ No If yes, where? _____

Parent/Guardian Information:

Parent/Guardian's Name_____ Preferred Language_____

Address_____City/Zip_____

Phone_____ _____ Email_____
HOME CELL

Emergency Contact_____
NAME PHONE RELATIONSHIP TO PATIENT

How did you hear about us? _____

◯ **Yes**, I do want my child to receive dental care at their school.

◯ **No**, I don't want my child to receive dental care at their school.

Has your child had any history of or conditions related to any of the following (Check all that apply):

- ◯ ADD/ADHD
- ◯ Anemia/Sickle Cell
- ◯ Arthritis
- ◯ Asthma
- ◯ Autism
- ◯ Bi-polar
- ◯ Bleeding disorder
- ◯ Bones/Joint
- ◯ Cancer
- ◯ Cerebral Palsy
- ◯ Depression
- ◯ Diabetes
- ◯ Downs Syndrome
- ◯ Epilepsy
- ◯ Fainting
- ◯ Hearing impaired
- ◯ Heart Condition
- ◯ Hepatitis
- ◯ Herpes
- ◯ HIV/AIDS
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Measles/Mumps
- ◯ Mononucleosis
- ◯ Parasites
- ◯ Pregnancy/due date
- ◯ Rheumatic Fever
- ◯ Seizures
- ◯ Thyroid
- ◯ Tobacco/drug use
- ◯ Tuberculosis
- ◯ Venereal disease
- ◯ Other serious illness or operations_____
_____

Does your child have any allergies/drug allergies? (i.e. Amoxicillin, Penicillin, etc)
◯ Yes ◯ No
Please List:

Is your child taking any medications?
◯ Yes ◯ No
Please List:

Does your child need pre-medication for a dentist appointment? (Prescribed by Dr.)
◯ Yes ◯ No
Please List:

Medical doctor/Clinic:
***(MUST CHECK ONE)**
- ◯ None
- ◯ Bellin_____
- ◯ Aurora_____
- ◯ Prevea_____
- ◯ Other _____

SIGNATURE NEEDED >>

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?

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 name) 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 authorize ForwardHealth to be billed for billable services.

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 preventative services. 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 have had the opportunity to read and review the Broken Appointment Policy. I understand that if my child fails 3 appointments within a 12-month period, they will not be seen at OHP clinics 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, any school districts where my children are enrolled, the Salvation Army Kroc Center, the OHP West, 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 14 months 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.

PLEASE INITIAL, PRINT & SIGN BELOW

_____ **(INITIAL)** **I have had an opportunity to review/obtain a copy of OHP's HIPAA Privacy Statement (available online at www.smilegb.org or by calling OHP). By my signature below, I authorize OHP to use, have access to, and disclose the protected health information of myself if I am the patient, my child, and or any other for whom I am the legally appointed guardian consistent with OHP's HIPAA privacy statement.**

_____

PRINT NAME OF PARENT/LEGAL GUARDIAN/PATIENT

_____ _____

SIGNATURE **DATE**