



Clinical preventive dental services provided are reserved for children up to the age of 19, who are eligible for the free/reduced lunch program, covered by public programs, are uninsured, or qualify as low income residents.

⚠️ Please do not fill out this form if your child has private dental insurance or an established dental home. ⚠️

Parent/Guardian Consent Form: (Please print clearly and complete the ENTIRE form)

ONE FORM PER CHILD Additional forms are available on our website: www.letssmileinc.com

All information is kept confidential.

Date: _____

Child's Name: _____ Child's nickname if any: _____
 Last Name First Name Middle Initial

Address: _____
 Street/Apt# City State Zip Code

Home Telephone: _____ Guardian's Cell: _____ Emergency Contact Name & Number: _____

Email address: _____

Date of Birth: ____/____/____ Age: _____ Male Female

Social Security # _____ (used ONLY for insurance verification and ensuring we have accurate statistics)

Race/Ethnicity (For statistical reasons only)

White /Caucasian Black/African American Hispanic/Latino Asian American Indian Somali

Do you need an interpreter? If yes, list language: _____

Medical History

- Is your child taking any medications? YES NO
- Please list any medications: _____
- Please list any allergies: _____
- Is your child currently under a doctor's care besides checkups? YES NO
- Does your child have any of the following conditions: If yes—please circle the condition

| | | | | | | | |
|--------------|-----------|---------------|-----------------|----------------|----------|-------------------|----------------|
| Asthma | ADD/ADHD | Autism | Cancer | Downs Syndrome | Epilepsy | Bleeding Problems | Heart Problems |
| Heart Murmur | Hepatitis | Latex Allergy | Rheumatic Fever | Tuberculosis | Diabetes | Seizures | Other |

DENTAL HISTORY

- Have you ever been told that your child needs to take antibiotics before any dental treatment? YES NO
- Is your child receiving fluoridated water? YES NO Is your child taking fluoride supplements? YES NO
- About how long has it been since your child last visited a dentist/hygienist? Please check one.
 - 6 months or less More than 6 months, but not more than 1 year ago
 - More than 1 year ago, but not more than 3 years ago More than 3 years ago
 - Never has been to the dentist/hygienist
 - Don't know/don't remember

**Name of Dental Office of any previous dental experiences: _____
- During the past 6 months, did your child have a toothache more than once, when biting or chewing? YES NO
- Does your child have any oral habits: thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, Etc.? YES NO
 If you answered "YES", please explain: _____
- What are YOUR concerns or questions regarding your child's teeth?

*Please check the type of insurance you have and provider number #

No Insurance MA MN Care South Country Health Alliance U-Care Blue Plus

_____, YES, I give permission for my child to receive clinical preventive dental care services that includes: a Basic Screening to evaluate, document, & advise of untreated decay to guardian/caregivers/ Collaborative Program Directors. Also includes oral cancer screening, dental cleaning, fluoride application, oral hygiene instruction, sealants, nutritional counseling regarding oral health, and referrals as needed.

I understand that these services are provided by a Collaborative Registered Dental Hygienist and it is not a replacement for a dental exam by a licensed dentist. A dental exam by a dentist is recommended least annually.

Printed name of Parent/Guardian: _____

Signature of Parent/Guardian: _____