Website: www.letssmileinc.com **Phone: 507-363-3023**

DENTAL nonprofit organization •based in Owatonna, MN 55060

Medical/Dental Health History and consent Form **(Please print clearly and complete the ENTIRE form)**

⬩Clinical preventive dental services provided are for children and adolescents ages birth to 19 years old, who are covered by State Insurance: Minnesota Health Care Plans (MHCP) such as MA, South Country Health Alliance, Blue Plus, UCare, or uninsured. ⬩Patients participating in our program who are enrolled in a state assistance program will have their services billed to insurance and the unpaid portion will be paid by grant funding. ⬩If patient is uninsured, Let's Smile, Inc. utilizes grant/donation funding to cover the cost of their services. ***⬩All dental services are at no charge to the families!⬩***

⬩Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

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

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

•Child's First Name ______________________Middle Name ___________ Last Name _______________________Child's nickname if any: _________________

•Date of Birth ______/______/______ Age_____________ ⬩Gender: ☐Male ☐ Female ☐ Prefer not to say/other

•Race/Ethnicity (*for statistical reasons only*) ⬩Please check all boxes that apply for the patient:
☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino American ☐ Asian ☐ Native American ☐ Somali ☐ Other

•Does the patient require an interpreter? ☐ Yes ⬩If yes, list language ______________________________ ☐ No

•Who is the main contact person for this patient? ____
⬩ Has the main contact for the family, (usually a parent or guardian) changed since your last visit? ☐ Yes ☐No

•Home Telephone: _____________________ Cell phone:_____________________ Accepts Text Messages? ☐ Yes ☐ No
• Emergency Contact Name & Number:______________________________

•Email address: ____ Accepts emails? ________ ☐ Yes ☐ No

•Mailing Address:____
Street/Apt# City State Zip Code
•***School*** ____________________________ (School-based dental clinics)

•**Dental Insurance:** Member PMI Number #______________________ ⬩ Social Security #___________________ (used *ONLY* to look up insurance verification)
☐ No Insurance ☐ MA ☐MN Care ☐ South Country Health Alliance (SCHA) ☐ U-Care ☐Blue Plus

DENTAL HISTORY:

•How long has it been since your child's last visit to a dental provider? Please check one.
☐ 6 months or less: *NOT DUE FOR SERVICES* ☐ More than 6 months, but not more than 1 year ago
☐More than 1 year ago, but not more than 3 years ☐More than 3 years ago ☐ Never has been to the dentist/hygienist
☐ Don't know/don't remember **Name of Dental Office of previous dental experiences: _____________________________

- Have you ever been told that your child needs to take antibiotics before any dental treatment? ☐YES ☐NO
- During the past 6 months, did your child have a toothache more than once, when biting or chewing? ☐YES ☐NO
- How often does your child brush teeth? ________________ Floss? _______________ Mouth rinse? ____________________
- Does your child's gums bleed when brushing teeth ☐Yes ☐No
- Does your child have any of the following oral habits:
☐ thumb sucking ☐nail biting ☐mouth breathing ☐pacifier ☐sleeping with a bottle ☐grinds teeth ☐ vape/smoke ☐chews smokeless tobacco
- What are *YOUR* concerns or questions regarding your child's teeth? ____

MEDICAL HISTORY:

Although dental personnel primarily treat the area in and around the mouth, the mouth is part of the entire body. Health problems or medication that may be taken could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

1. Please list any prescribed medications or over the counter medications: ____
2. Please list any allergies:____
3. Does your child have any of the following conditions: ☐Yes- If yes, please circle the condition ☐ No

Asthma	*ADD/ADHD*	*Autism*	*Cancer*	*Downs Syndrome*	*Epilepsy*	*Bleeding Problems*	*Heart Problems*
Heart Murmur	*Hepatitis*	*Latex Allergy*	*Rheumatic Fever*	*Tuberculosis*	*Diabetes*	*Seizures*	*Other (please list)*

AUTHORIZATION:

-I authorize Let's Smile, Inc. to perform clinical preventive dental care services as may be necessary for the patient's proper dental care. ★*ALL patients will receive a fluoride treatment. Please print NO if you do not consent to fluoride treatment*_____________

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

-I consent to allow Let's Smile, Inc. to use my / my child's / my children's image, voice, and/or words in informational materials such as reports, brochures, videos, etc., and for media interviews. I waive all claims for compensation and release Let's Smile, Inc. from any liability related to such use.

★ *Please print NO if you do not consent to the photo portion of the form*: ___________

-I authorize payment of insurance benefits directly to Let's Smile, Inc. I understand that my dental insurance may pay less or not cover all services rendered. I understand if services are denied or insurance is inactive, Let's Smile, Inc. is responsible for unpaid charges. To my knowledge, all above information is correct and accurate.

⬩Printed name of Parent/Guardian:______________________________ ⬩ Signature of Parent/Guardian: _______________________________ ⬩ Date_____________