



Protecting All Smiles Public Health Dental Hygiene

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

Return to your child's teacher tomorrow. **ONE FORM PER CHILD.**

Additional forms are available on our website: **protectingallsmiles.com**

All information is kept confidential.

Date: _____

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

Address: _____
Street/Apt# City State Zip Code

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

Email Address: _____

Date of Birth: ____/____/____ Age: _____ ☐ Male ☐ Female Child's Grade _____ Child's Room #: _____

RACE/ETHNICITY (For statistical reasons only)

☐ Hispanic/Latinx ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian ☐ Other

What Language does the child speak at home? _____

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

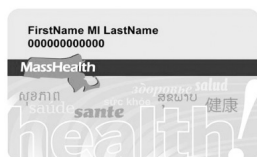
Asthma	ADD/ADHD	Autism	Cancer	Downs Syndrome	Epilepsy	Bleeding Problems	Heart Problems
Heart Murmur	Hepatitis	Latex Allergy	Rheumatic Fever	Tuberculosis	Diabetes	Seizures	Other, please list

DENTAL HISTORY:

6. Have you ever been told that your child needs to take antibiotics before any dental treatment? YES / NO
7. 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 previous dental experiences: _____
8. During the past 6 months, did your child have a toothache more than once while biting or chewing? YES / NO
9. Would you like help finding a permanent dental home? YES / NO
10. What are YOUR concerns or questions regarding your child's teeth? _____

***Please check the type of insurance you have AND write Member Number #** _____

☐ MassHealth



☐ Private Insurance (name) _____

☐ No Dental Insurance

I give permission for my child to receive clinical preventive dental care services. I understand that this consent will stay in effect for two years. If dental sealants are placed, they will be re-checked and replaced the next visit if needed. It is the parent/guardians responsibility to inform the dental provider of any changes in their child's medical information. I understand that a copy of my child's dental history and findings will be given to our community partner and that all the information about my child will be kept confidential. If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. Protecting All Smiles, LLC. will make every effort NOT to interfere with your regular dental appointments. I have been given a copy of the Protecting All Smiles, LLC. Notice of Privacy Practices. I have read and understand the dental program and I consent to have my child participate. I authorize the dental program to forward any referrals to my child's dentist of record when applicable. Protecting All Smiles, LLC. does not bill families directly for the preventive services we provide. **I understand that these services are provided by Public Health Dental Hygienists and the screening is not a replacement for a dental exam by a dentist. A dental exam by a dentist is recommended yearly.**

X _____
Printed name of Parent/Guardian

Signature of Parent/Guardian