El Dorado Smiles Dental Van

El Dorado Community Health Centers
Placerville • Diamond Springs • Cameron Park
Dental: (530) 497-5016 Fax: (530) 622-8908 www.edchc.org

Health History and Consent Form

Child's Name:_____Grade:_____
Last name | First Name | Middle

How did you hear about the Dental Van? ( ) School ( ) EDCHC Staff ( ) Doctors Office ( ) Other_____

Child's School:_____ Childs's Teacher_____

Patient Date of Birth: ____/____/____ Gender on birth certificate □ Male □ Female SSN: _____ -_____-_____
MM DD YYYY

Address:_____(Currently homeless) Y N
Street/PO City Zip

Parent/Guardian information:
1st Full name: _____ Date of Birth of Guardian: ___/___/____
MM DD YYYY

Telephone:_____Cell_____Work_____

Social Security: _____-_____-_____ Relationship to patient: ☐ Mother ☐ Father ☐ Other_____

2nd Full name: _____ Date of Birth of Guardian: ___/___/____
MM DD YYYY

Telephone:_____Cell_____Work_____

Social Security: _____-_____-_____ Relationship to patient: ☐ Mother ☐ Father ☐ Other_____

Is the child a decedent of an agricultural worker? Y N If yes circle one: Migrant or Seasonal

Primary or Preferred Language:_____

Ethnicity (mark one): □ Hispanic/Latino: □ Non-Hispanic/Latino □ Unreported /Refused to report

Race mark all that apply):

□ White
□ Asian
□ American Indian/Alaska Native
□ Black/African American
□ Native Hawaiian/Other Pacific Islander
□ Unreported/Refused to report

Number of people in the household? _____ Monthly Household Income? _____

Emergency Contact:_____Relationship to Patient:_____

Home Phone Number:_____ Cell:_____

Dental Insurance Name: _____Policy# :_____

Medical Insurance Name: _____Policy #: _____

Does your child have a Dentist? Name:_____Last Visit:_____

Preferred Pharmacy Name:_____ Location:_____

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Does your child have, or has your child had:

Persistent Cough	**Y**	**N**	Congenital Heart Disease	**Y**	**N**	Latex Allergies	**Y**	**N**
Persistent Sore Throat	**Y**	**N**	Rheumatic Heart Disease	**Y**	**N**	Asthma	**Y**	**N**
Persistent Fever	**Y**	**N**	Heart Murmur	**Y**	**N**	Diabetes	**Y**	**N**
Vaccine for MMR & TB	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**	Bleeding Problems	**Y**	**N**
TB Skin Test	**Y**	**N**	Exposure to an Airborne Disease	**Y**	**N**	HIV or AIDS	**Y**	**N**
TB Test Results	**Y**	**N**	Epilepsy or Seizures	**Y**	**N**	Hepatitis	**Y**	**N**
Take Fluoride Vitamins	Y	N	Nervous or Mental Disorder	**Y**	**N**	Anemia	**Y**	**N**

If your child had a positive TB skin test, did they have a chest x-ray? Y N Explain_____
Is your child taking any medications? Y N If yes, what medications? _____
Has your child been hospitalized in the last year? Y N If yes, for what? _____
Did your child experience any complications while in the hospital? Y N Explain: _____
Does your child have any allergies (including allergies to medication like penicillin)? Y N
If yes, what medications or other allergic reactions? _____
Is your child experiencing any dental problems? Y N Explain: _____
Is there anything else we should know about the health of your child? _____

The information I have submitted on this form is true to the best of my knowledge.

I give consent for my child to be taken from class by dental van staff to be seen on the Children's Dental Van for a dental examination which may include the following: dental x-rays, dental exam, fluoride treatments, dental cleaning, sealants (protective covering over the teeth), or temporary therapeutic restorations.

I understand that in the course of the examination, the dentist will plan treatment for necessary dental procedures. I will review the dental treatment recommendations that are sent home with my child after the examination. I understand that I will be contacted to obtain my consent to perform the dental treatment recommendations, to confirm my child's follow-up appointment or for any reason regarding my child's treatment.

I authorize my child's insurance benefits be paid directly to El Dorado County Community Health Center. I also authorize El Dorado Community Health Center or insurance company to release any information required to process my claims. I understand that I am responsible to maintain my insurance eligibility and for any charges incurred during dental treatment that may not be covered by the insurance organization.

I give consent for Dental Van staff to release my child's information to any of the partners involved with the dental van. This includes, but is not limited to El Dorado County Community Health Center, EDCOE, Head Start, EDC Public Health Division.

I promise to notify the dental van staff 24 hours in advance to cancel or change an appointment. If less notice is given to staff, my appointment will be considered a missed appointment. I understand that a missed appointment is taken very seriously. Missing 2 appointments without proper notice within the same calendar year will require a written letter to the dental director to schedule any future appointments.

Name of Parent/ Guardian (Please print)_____Relation to Patient_____

☆ **Signature**: _____Date:_____

I hereby acknowledge receipt of El Dorado Community Health Centers Notice of privacy practices.

☆ **Signature**:_____Date:_____