Consent for Dental Services
at
Cincinnati Health Department Dental Clinics

Dear Parent,

Your child has been identified as having a dental problem/pain and can receive treatment for the problem at a Cincinnati Health Department Dental Clinic. If you would like your child to be taken to the clinic by bus and receive dental treatment, please complete the following forms and return them to your school nurse.

Permission for Transportation

☐ Yes, I give permission for my child to be transported to a Cincinnati Health Department Dental Clinic for dental treatment.

Permission for Dental Treatment

(Please Print)

Name ____

Last **First** **MI**

DOB ______________ **Age** _______ **Social Security #** _________________________

Race _______________ **Sex** __________ **School** _____________________________

Address ____ **Apt** _____________

City ____________________________ **State** _____________ **Zip Code** _________

Home Phone ( ) ______________ **Parent's Work Phone ( )** _______________

Emergency Contact __________________________ **Phone ( )** _______________

I hereby request that the Cincinnati Health Department provide my child with dental services. I give clinic staff permission to perform all examinations, tests and treatments as needed for me or my child's medical/dental care. I also understand that I or my child will receive these clinical services as performed by qualified staff regardless of gender unless otherwise requested.

Signature ____**Date** ________________

Parent/Legal Guardian

Name of Parent ___________________________________ **Parent's DOB** ___________

Parent's S.S.# ___________

Place of Employment ____

Medicaid/CHIP/Healthy Start Yes_____ No_____ Case Number_________________

Care Source/Amerigroup Yes_____ No_____ Case Number ____________________

Dental Insurance Yes_____ No _____ Company Name _______________________

Billing Number ________________________

►► ____ By initialing here, I acknowledge receipt of the CHD Notice of Privacy Practices.

DENTAL PROGRAM
HEALTH HISTORY

Child's Name____________________________Date of Birth___________ Today'sDate____________

Address____Phone#____________________

School____Grade_________RoomNumber__________
_

1.When was your child's last visit to the dentist? ____

2. Has your child had heart surgery? ☐ Yes ☐ No
   If yes, please explain____________________________________
   ____

3. Has your child had any other serious health problems? ☐ Yes ☐ No
   If yes, please explain____________________________________
   ____

4. Does your child take any medication? ☐ Yes ☐ No
   If yes, please list____

5. Is your child allergic to any medications or drugs? ☐ Yes ☐ No
   If yes, please list____

6. Has your child ever had problems during or after a visit to the dentist? ☐ Yes ☐ No
   If yes, please describe____________________________________
   ____

7. Is there any chance your child could be pregnant? ☐ Yes ☐ No

8. Has your child had any of the following:

Diabetes	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hives	☐ Yes	☐ No
Nervous Disorder	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
HIV/Aids	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
ADD/ADHD (Attention Deficit Disorder)	☐ Yes	☐ No	Other______________________________		

♦♦**Signature of Parent/Legal Guardian**______________________________ **Date**_______________