TeamSmile®
Dental and Sports Professionals Teaming Up To Provide Free Dental Healthcare

Patient Consent for Dental Treatment and Health History

Please complete this form, front and back, and sign as parent or guardian for your child ("patient").

TeamSmile will provide free dental care and preventative care including, but not limited to, diagnostic exams, x-rays, professional cleanings, sealants, fillings, extractions, pulpotomies, crowns, while educating the patient on the value of a life-long commitment to oral health care.

Information About Your Patient To Be Completed by Parent or Guardian

Organization Patient is with: _____
Patient's Name: _____
Age: _____ **Patient's Date of Birth:** _____ **Patient's Gender: Male** _____ **Female** _____
Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Medicaid Eligible: Yes _____ **No** _____ **Free & Reduced Lunch: Yes** _____ **No** _____
Race (circle one) Caucasian American Indian African American Asian Hispanic Other _____
Language(s) spoken in home _____

Name of Parent/Guardian: _____ **Relationship to Patient:** _____
Marital Status: Married _____ **Single** _____ **Divorced** _____ **Widowed** _____
Home Phone: _____ **Cell/Mobile Phone:** _____

IN CASE OF EMERGENCY CONTACT on the day of service:
First Name: _____ **Last Name:** _____
Preferred Phone: _____ **Alternative Phone:** _____

By checking each box, you agree to the following statement:

- ☐ I consent to the patient participating in face painting
- ☐ I consent to the patient participating in physical activities while at the program (i.e. jump rope, ball toss, yoga)
- ☐ I consent to the patient being filmed/photographed with the understanding it may be used for promotional purposes

(Failure to check above boxes will not affect ability to receive treatment.)

Name of Parent/Guardian (Printed) _____

Signature _____ **Date** _____

By checking each box, you agree to the following statement:

- ☐ To the best of my knowledge, the medical history questions on page 2 have been answered correctly and accurately.
- ☐ I give consent for the patient to receive preventative care to help prevent and diagnose tooth decay and gum disease which may include, but is not limited to, x-rays, dental cleaning, fluoride and/or sealants (sealants cover the chewing part of the tooth to provide extra protection.)
- ☐ I give consent for the patient to receive local anesthetic (numbing of the teeth) and dental treatment which may include, but is not limited to, fillings, stainless steel crowns and pulpotomies, all performed by a TeamSmile dentist.
- ☐ I give consent for the patient to receive local anesthetic (numbing of the teeth) and dental treatment, which may include extractions, performed by a TeamSmile dentist.

I understand the patient will not get dental treatment unless my consent is given. I further understand that no promise, guaranty or warranty has been made regarding the results of any treatment or procedure. I understand that there are inherent risks in any dental treatment, including but not limited to swelling, bruising, allergic reaction, changes in pain, etc. By signing below, you agree to NOT hold TeamSmile or its volunteers liable for performing any preventative care or dental treatment diagnosed and recommended by licensed dental professionals. TeamSmile's mission is to provide your patient free dental and preventative care. You may revoke this consent at any time, except to the extent it has been relied upon, by emailing a written request to: info@teamsmile.org. I attest that I understand the information on this form and that I have been given the opportunity to ask any questions that I may have.

Name of Parent/Guardian (Printed) _____

Signature _____ **Date** _____

Health History
Form Must be Completed for Treatment

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

Is your patient under a physician's care now?	☐ Yes ☐ No	If yes, explain: _____
Is your patient taking any medications?	☐ Yes ☐ No	If yes, explain: _____
Has your patient been hospitalized due to a dental emergency?	☐ Yes ☐ No	If yes, explain: _____
Has your patient ever seen a dentist before?	☐ Yes ☐ No	
Does your patient presently have a dental home?	☐ Yes ☐ No	
Is your patient having any dental pain now?	☐ Yes ☐ No	

Is there anything else we should know about the health of your patient? List below: _____

_____

Is your patient allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local anesthetic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Peanut Allergy ☐ Nut Allergy
☐ Other If yes, please explain: _____

Does your patient have, or have they had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular heartbeat	☐ Scarlet Fever
☐ Anemia	☐ Cold/Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Angina	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Convulsions	☐ Heart Attack	☐ Liver Disease	☐ Sinus Trouble
☐ Artificial Joint	☐ Cortisone Medicine	☐ Heart Murmur	☐ Low Blood Pressure	☐ Spina Bifida
☐ Asthma	☐ Diabetes	☐ Heart Pace Maker	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Heart Trouble	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood transfusion	☐ Excessive Bleeding	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Breathing Problem	☐ Excessive Thirst	☐ Hepatitis A	☐ Parathyroid disease	☐ Thyroid Disease
☐ Bruise Easily	☐ Fainting Spells/dizziness	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tonsillitis
☐ Cancer	☐ Frequent Cough	☐ Herpes	☐ Radiation Treatments	☐ Tuberculosis
☐ Chemotherapy	☐ Frequent Diarrhea	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers	☐ Rheumatic Fever	☐ Yellow Jaundice
☐ Ear tubes	☐ Recurrent ear infections	☐ Hearing loss		

Has your patient ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

_____

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform TeamSmile of any changes to the patient's medical status.

Signature of Parent/Guardian_____ **Date:**_____

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