



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
• Is your home water supply fluoridated? 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 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

Table with 8 columns: Asthma, ADD/ADHD, Autism, Cancer, Downs Syndrome, Epilepsy, Bleeding Problems, Heart Problems. Row 2: 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.
-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 _____