Website: www.letssmileinc.com **Phone: 507-455-4063**

DENTAL nonprofit organization based in Owatonna, MN

Medical/Dental Health History and consent Form **(Please print clearly and complete the ENTIRE form)**

★Let's Smile dental services are available for children and teens enrolled in State/County Insurance: Minnesota Health Care Plans (MHCP) including MA, South Country Health Alliance, Blue Plus, UCare, as well as uninsured patients.
★If enrolled in a state/county assistance program, service fees will be billed to insurance, with unpaid amounts covered by grants/donations. Uninsured patients will also have fees covered by grants and donations. ***All dental services are provided at no charge to families thanks to grant/donation funding***

◆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? ☐ No ☐ Yes ◆If yes, list language ______________________________
- Name of 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 #__________________ (ONLY needed if PMI # is not provided)
☐ 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 previous Dental Clinic experience: _____________________________
- Have you ever been told that your child needs to take antibiotics before any dental treatment? ☐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 of the following 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.*

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: ☐ No ☐Yes- If yes, please circle the condition

ADD/ADHD	*Anxiety*	*Asthma*	*Autism*	*Bleeding Problems*	*Cancer*	*Diabetes*	*Down Syndrome*
Epilepsy	*Heart Murmur*	*Heart Problems*	*Hepatitis*	*Latex Allergy*	*Tuberculosis*	*Seizures*	*Other (please list)*

AUTHORIZATION:

I authorize Let's Smile, Inc. to perform necessary clinical preventive dental care services for the patient's dental care such as screening, cleaning, sealants, and fluoride.
I understand that these services are provided by a Collaborative dental professional. A dental exam by a Dentist/Advanced Dental Therapist is recommended at least annually.

★All patients will receive a ***fluoride*** treatment _unless_ you circle no to decline. **NO**

I authorize Let's Smile, Inc. to perform necessary follow up restorative dental procedures, including X-rays, Silver Diamine Fluoride (SDF) application, fillings, extractions, and the use of nitrous oxide as deemed appropriate for my child's treatment.

I give permission to Let's Smile, Inc. to use my/my child's image, voice, and/or words in social media, reports, brochures, videos, etc.,I agree that I will not receive any payment for this and I release Let's Smile, Inc. from any responsibility or legal claims associated with using this material. Please circle one for **Photo consent**: **YES** / **NO**

-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 dental services are provided at no charge to families thanks to grant/donation funding. **To my knowledge, all above information is correct and accurate.**

◆Printed name of Parent/Guardian:_____________________________ ◆ Signature of Parent/Guardian: ______________________________ ◆ Date____________