Website: **www.letssmileinc.com** **Phone:** **507-363-3023**

Outreach organization • Owatonna, MN 55060

Clinical preventive dental services provided are reserved for children up to the age of 19, who are eligible for the free/reduced lunch program, covered by public programs, are uninsured, or qualify as low income residents.

⚠**Please do not fill out this form if your child has private dental insurance or an established dental home.** ⚠

Parent/Guardian Consent Form: (Please print clearly and complete the ENTIRE form)

ONE FORM PER CHILD Additional forms are available on our website: www.letssmileinc.com

All information is kept confidential. **Date: _____**

Child's Name: _____ Child's nickname if any: _____
Last Name First Name Middle Initial

Address: _____
Street/Apt# City State Zip Code

Home Telephone: _____ Guardian's Cell:_____ Emergency Contact Name & Number:_____
Email address: _____

Date of Birth: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Social Security #_____ (used ONLY for insurance verification and ensuring we have accurate statistics)

Race/Ethnicity (For statistical reasons only)
☐ White /Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian ☐ Somali

Do you need an interpreter? If yes, list language: _____

Medical History

1. Is your child taking any medications? YES NO
2. Please list any medications: _____
3. Please list any allergies:_____
4. Is your child currently under a doctor's care besides checkups? YES NO
5. Does your child have any of the following conditions: If yes—please circle the condition

Asthma	*ADD/ADHD*	*Autism*	*Cancer*	*Downs Syndrome*	*Epilepsy*	*Bleeding Problems*	*Heart Problems*
Heart Murmur	*Hepatitis*	*Latex Allergy*	*Rheumatic Fever*	*Tuberculosis*	*Diabetes*	*Seizures*	*Other*

DENTAL HISTORY

6. Have you ever been told that your child needs to take antibiotics before any dental treatment? YES NO
7. Is your child receiving fluoridated water? YES NO Is your child taking fluoride supplements? YES NO
8. About how long has it been since your child last visited a dentist/hygienist? Please check one.
   - ☐ 6 months or less
   - ☐ More than 6 months, but not more than 1 year ago
   - ☐ More than 1 year ago, but not more than 3 years ago
   - ☐ More than 3 years ago
   - ☐ Never has been to the dentist/hygienist
   - ☐ Don't know/don't remember

   **Name of Dental Office of any previous dental experiences: _____
9. During the past 6 months, did your child have a toothache more than once, when biting or chewing? YES NO
10. Does your child have any oral habits: thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, Etc.? YES NO
    If you answered "YES", please explain:
    _____
    _____
11. What are *YOUR* concerns or questions regarding your child's teeth?
    _____
    _____

***Please check the type of insurance you have and provider number #_____**

☐ No Insurance ☐ MA ☐ MN Care ☐ South Country Health Alliance ☐ U-Care ☐ Blue Plus

_____YES, I give permission for my child to receive clinical preventive dental care services that includes: a Basic Screening to evaluate, document, & advise of untreated decay to guardian/caregivers/ Collaborative Program Directors. Also includes oral cancer screening, dental cleaning, fluoride application, oral hygiene instruction, sealants, nutritional counseling regarding oral health, and referrals as needed**.**

I understand that these services are provided by a Collaborative Registered Dental Hygienist and it is not a replacement for a dental exam by a licensed dentist. A dental exam by a dentist is recommended least annually.

Printed name of Parent/Guardian:_____ Signature of Parent/Guardian: _____