El Dorado Smiles Dental Van

El Dorado Community Health Centers
Placerville • Diamond Springs • Cameron Park
Dental: (530) 497-5016 Fax: (530) 622-8908 www.edchc.org

Health History and Consent Form

Child's Name: _____ Grade: _____
Last name | First Name | Middle

How did you hear about the Dental Van? ( ) School ( ) EDCHC Staff ( ) Doctors Office ( ) Other

Child's School: _____ Childs's Teacher _____

Patient Date of Birth: ____/____/____ Gender on birth certificate □ Male □ Female SSN: ____ -____-_____
MM DD YYYY

Mailing Address: _____
Street/PO City Zip

Parent/Guardian information:

1st Full name: _____ Date of Birth of Guardian: ____/___/___
MM DD YYYY

Telephone: Home _____ Cell_____ Work_____

Social Security: _____ -_____-_____ Relationship to patient: □ Mother □ Father □ Other_____

2nd Parent/Guardian or Emergency Contact

Full name: _____ Date of Birth: ____/___/____
MM DD YYYY

Telephone: Home _____ Cell_____ Work_____

Social Security: _____ -_____-_____ Relationship to patient: □ Mother □ Father □ Other_____

Preferred Language: _____

Preferred Pharmacy Name:_____Location: _____

Is the child a decedent of an agricultural worker? Y N If yes circle one: Migrant or Seasonal	
Currently homeless Y N □ In your car □ In a shelter □ In a hotel □ On the street □ With another family □ Other	
Number of people in the household? _____ Monthly Household Income? _____	
Ethnicity (mark one): □ Hispanic/Latino: □ Non-Hispanic/Latino □ Unreported /Refused to report	
Race:	□ White □ Asian □ American Indian/Alaska Native □ More than one race □ Black/African American □ Native Hawaiian □ Other Pacific Islander □ Unreported/Refused to report

Primary Dental Insurance Name: _____Policy #:_____
Secondary Dental Insurance Name: _____Policy #: _____
Medical Insurance Name: _____Policy #: _____
Does your child have a Dentist? Name_____Last Visit:_____

Uninsured patients may be eligible to receive a discount through the sliding fee program. Discounts are based off family size and household income. Our staff can help you with questions regarding health care and dental care plan options.

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Does your child have, or has your child had:

Persistent Cough	Y	N	Congenital Heart Disease	Y	N	Latex Allergies	Y	N
Persistent Sore Throat	Y	N	Rheumatic Heart Disease	Y	N	Asthma	Y	N
Persistent Fever	Y	N	Heart Murmur	Y	N	Diabetes	Y	N
Vaccine for MMR & TD	Y	N	Mitral Valve Prolapse	Y	N	Bleeding Problems	Y	N
TB Skin Test	Y	N	Exposure to an Airborne Disease	Y	N	HIV or AIDS	Y	N
TB Test Results	P	N	Epilepsy or Seizures	Y	N	Hepatitis	Y	N
Take Fluoride Vitamins	Y	N	Nervous or Mental Disorder	Y	N	Anemia	Y	N

If your child had a positive TB skin test, did they have a chest x-ray? Y N Explain_____
Is your child taking any medications? Y N If yes, what medications? _____
Has your child been hospitalized in the last year? Y N If yes, for what? _____
Did your child experience any complications while in the hospital? Y N Explain: _____
Does your child have any allergies (including allergies to medication like penicillin)? Y N
If yes, what medications or other allergic reactions? _____
Is your child experiencing any dental problems? Y N Explain: _____
Is there anything else we should know about the health of your child? _____

The information I have submitted on this form is true to the best of my knowledge.

I give consent for my child to be taken from class by the El Dorado Community Health Center (EDCHC) staff to be seen on El Dorado Smiles Dental Van or in a classroom for an exam and treatment which may include the following: tele-dentistry consult, dental x-rays, intra-oral and extra-oral photographs, dental exam, fluoride treatments, dental cleaning, sealants (protective covering over the teeth), or temporary therapeutic restorations. For more information on the tele-dentistry consult and method of dental examination, please refer to the 'Tele-dentistry Consultation' Information sheet. If you have further questions, you can call the clinic at (530) 497-5016.

I understand that I will receive a call from the dental office 5-7 business days after my child has been seen about the findings of the tele-dentistry consult and any future treatment that may be needed. I promise to notify the EDCHC staff 24 hours in advance to cancel or change an appointment. If less notice is given to staff, my appointment will be considered a missed appointment. I understand that a missed appointment is taken very seriously. Missing 2 appointments without proper notice within the same calendar year will require a written letter to the dental director to schedule any future appointments.

I authorize my child's insurance benefits be paid directly to El Dorado Community Health Center. I also authorize El Dorado Community Health Center or insurance company to release any information required to process my claims. I understand that I am responsible to maintain my insurance eligibility and for any charges incurred during dental treatment that may not be covered by the insurance organization.

NOTICE OF PRIVACY PRACTICES: I give consent to the EDCHC staff to release my child's information to any of the partners involved. This includes, but is not limited to El Dorado Community Health Center, EDCOE, Head Start, EDC Public Health Division.

Name of Patient:_____ Print Name of Parent/ Guardian_____

☆ Signature of Parent/guardian: _____Date:_____Relation to Patient:_____

I hereby acknowledge receipt of the 'Tele-dentistry Information Sheet' and agree to have the above named patient participate in a tele-dentistry consult.

☆ Signature:_____Date:_____