Permission Form for Give Kids a Smile Dental Program

Please PRINT in ink within the boxes

Child's first name	Child's last name	Child's birth date	Child's gender
		___/___/___	M ☐ F ☐

Parent/guardian's first name(s)	Parent/guardian last name(s)

Address	City	State	Zip

First Phone#:

Second Phone #:

Email Address:

Emergency Contact: _____

Contact's Phone #: _____

What race do you consider your child?

Black ☐ White ☐ Multiracial ☐ Asian ☐ Hawaiian Native ☐

American Indian/Native Alaskan ☐ Other Pacific Islander ☐

Other ☐ _____

What heritage do you consider you child?:

Hispanic/Latino ☐ Not Hispanic/Latino ☐

Child's Medicaid Recipient ID Number (7 digit number and 1 letter on back of Medicaid card)

Child's school	Teacher	Grade

Is your child eligible?

What type of dental insurance does your child have?

1. **Dental** insurance: ☐ United Concordia ☐ Delta Dental ☐ Metlife ☐ Aetna ☐ Other_____
2. ☐ Medicaid (Medical Card, Title 19), ☐ Meridian, or ☐ Hawk-i
3. ☐ No dental insurance (**PLEASE NOTE** - Uninsured patients may be limited to 1 visit per lifetime depending on program funding.)

Where does your child go for dental care?

1. **When was your child's last dental visit?** _____
2. **Where does your child go for dental care?** Name of dentist/office: _____
3. **Has your child been seen on the GKAS dental bus before?** ☐ Yes or ☐ No

For office use only:

PLEASE SEE OTHER SIDE ➡

For more information: www.bethany-qc.org/give-kids-a-smile.php

Important Health History:

Your child's Medical History [Complete both columns]

Anemia	Yes ☐ No ☐	Heart Ailment or Angina	Yes ☐ No ☐
Blood Disorder	Yes ☐ No ☐	Heart Murmur, Heart Defect	Yes ☐ No ☐
Bleeding Disorder	Yes ☐ No ☐	Artificial Heart Valve	Yes ☐ No ☐
High Cholesterol	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐
Thyroid Problems	Yes ☐ No ☐	High/Low blood Pressure	Yes ☐ No ☐
Leukemia	Yes ☐ No ☐	Pace Maker	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Artificial Joints	Yes ☐ No ☐
Radiation Treatment	Yes ☐ No ☐	Rheumatoid Arthritis	Yes ☐ No ☐
Osteoporosis	Yes ☐ No ☐	Chronic Pain	Yes ☐ No ☐
Hepatitis and/or Liver Problems	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐	Stomach Disorder	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
HIV/AIDS	Yes ☐ No ☐	Seizure Disorder	Yes ☐ No ☐
Downs Syndrome	Yes ☐ No ☐	Brain Injury	Yes ☐ No ☐
Autism	Yes ☐ No ☐	Cerebral Palsy	Yes ☐ No ☐
Fainting/Dizziness	Yes ☐ No ☐	Pregnancy	Yes ☐ No ☐
Hearing Difficulties	Yes ☐ No ☐	Fever Blisters and/or Cold Sores	Yes ☐ No ☐
Chronic Earaches	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
ADHD/ADD	Yes ☐ No ☐	Mental/Physical Disabilities	Yes ☐ No ☐
Asthma Yes ☐ No ☐	Carries Inhaler? Yes ☐ No ☐	Triggers for Asthma:	
Any Surgeries?	Yes ☐ No ☐	List Surgeries/Dates:	
Caffeine Use?	Yes ☐ No ☐	If so, how much/how often?	
Allergies:		**Does your child need an antibiotic before a dental procedure?**	Yes ☐ No ☐
Latex	Yes ☐ No ☐		
Nut	Yes ☐ No ☐	**List Medications Taken:**	
Food	Yes ☐ No ☐		
Anesthetics	Yes ☐ No ☐		
Metal	Yes ☐ No ☐		
Others	Yes ☐ No ☐		
Please List:			

Medication	Dose	How often?

Your Child's Dental History

Gum Disease	Yes ☐ No ☐	TMJ	Yes ☐ No ☐
Bleeding Gums	Yes ☐ No ☐	Teeth Grinding	Yes ☐ No ☐
Easily Gags	Yes ☐ No ☐	Difficulties Chewing Food	Yes ☐ No ☐
Sensitive and/or Painful Teeth	Yes ☐ No ☐	Lip Sucking	Yes ☐ No ☐
Nail Biting	Yes ☐ No ☐	Thumb Sucking/Pacifier Use	Yes ☐ No ☐
Mouth Breather	Yes ☐ No ☐	Speech Impairments	Yes ☐ No ☐
Brushing two times per day	Yes ☐ No ☐	Flossing Daily	Yes ☐ No ☐
Tobacco Use	Yes ☐ No ☐	Sticky Food Consumption	Yes ☐ No ☐
		How often:	

Type Used	How Often?

Sweet Consumption	Yes ☐ No ☐
How often:	
Soda/Pop Consumption	Yes ☐ No ☐
How often:	

For office use only:

Sealants Placed: 2 ☐ 3 ☐ 14 ☐ 15 ☐ 18 ☐ 19 ☐ 30 ☐ 31 ☐

Health History reviewed by: _____ Dentist's Initials _____ Date: _____

WAIVER

Please read the waiver below and initial after each permission if agreed to.

I give permission for my child to be treated on the dental bus provided by Bethany for Children & Families' Give Kids a Smile Dental Program. _____ **Initial**

I give permission for Bethany for Children & Families to transport my child from their school to the dental bus if it needs to be parked off-site. _____ **Initial**

I give permission for my child to be treated in a dental office/clinic if follow up work is needed. _____ **Initial**

I give permission for Bethany for Children & Families to transport my child to a follow up dental appointment, if I am not able to take or do not have transportation. Transportation will be arranged on a case by case basis. _____ **Initial**

If my child needs a specialist: Pedodontist (child dentist), endodontist (root canal), Oral Surgeon (tooth extractions), Periodontist (Gum Disease), or Orthodontist (braces), I agree to go with my child to this appointment. _____ **Initial**

I give permission for audits to be performed and professional providers to return to my child's school to recheck his/her sealants and reseal if needed. _____ **Initial**

X Signature _____ **Date** _____

Parent/Guardian/Legal Custodian Signature

I, as the parent or guardian, have received a copy of the Give Kids a Smile® Notice of Privacy Practices.

Permission and acknowledgement valid for one year from the date of signature

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For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Give Kids a Smile®

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Dentists participating in the Give Kids a Smile® program may be required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile® Program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile® Program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile® Dental program, and will remain in effect until we replace it.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In Care: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the Notice for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 years, but not before April 14, 2003.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.