



Pediatric Dental Program Permission and Medical History Form

Please print in black ink and return to teacher or care provider

Child's Name: _____ Date of birth: ___ / ___ / ___ Male Female
(First) (M.I.) (Last) (mo. / day / year)
 Grade: _____ Room #: _____ Teacher: _____ School: _____
 Home Address: _____ City: _____ Zip: _____
 Parent's Email: _____ **GO TO: masshealthysmiles.com for form in other languages**

YES, by completing this form I give permission for my child to participate in the preventive school based dental program. I approve billing my insurance company for services provided. *Please check YES, complete entire form and sign below.*

NO, I do not want my child to participate in this program. *Please complete name and grade only.*


General Information:

1. What language does your *child* speak best? _____ What language is spoken at home? _____
2. What is your *child's* race?
 Caucasian/White Asian Black/African American Hispanic/Latino More than One Other _____

Health Information:

3. Does your child see a doctor for regular checkups? YES NO **If yes**, please name _____
4. Does your child see a dentist for regular checkups? YES NO **If yes**, please name _____
5. In general, how would you describe the health of your child's teeth and mouth? Date last dental visit _____
 Excellent Very Good Good Fair Poor
6. Is your child taking any medication now? YES NO **If yes**, please list: _____
7. Has a dentist/doctor ever said your child needs antibiotics (penicillin) before dental treatment? YES NO
8. Please check any illnesses or conditions your child has EVER had:
 ADD/ADHD Diabetes Hepatitis Rheumatic Fever Convulsions
 Anemia Epilepsy Heart Murmur Seizures Allergies to Medicine
 Asthma Heart Conditions Kidney/Liver Tuberculosis HIV/AIDS
9. Does your child have any other health conditions? YES NO **If yes**, please list: _____
10. Does your child have allergies? YES NO **If yes**, please check all that apply or explain: _____
 Antibiotics Penicillin Colophonium Aspirin Latex Resin/Rosin Food/Other: _____
11. Does child have dental insurance? YES NO **If yes** complete below **If no**, would you like help getting it? YES NO

MassHealth Patient Information (only)

Child's Name on card: _____
 Insurance Number (RID) – 12 digit # _____


Dental Insurance Company Information (not MassHealth)

Company: _____
 Address: _____
 Subscriber: _____
 Subscriber ID # _____
 Subscriber Date-of-Birth (mo/dy/year) ___ / ___ / ___
 Group/ Policy # _____
 Employer Name: _____

I understand that MASS Healthy Smiles LLC may use this health information for treatment, payment, and health care operations. I have received Right to Privacy and Program information. I have read and understand the dental program and services that may be provided to my child and consent that my child participates in this program. I understand that these services do not substitute for an examination by a dentist. I understand that my child should obtain an examination by a dentist within 90 days. I understand that my child may continue to obtain dental care through any other provider. I authorize the dental program to provide a written summary of services provided to a designated school official and to forward any referrals to my child's dentist of record when applicable. I understand that the program will provide a list of dentists in my area and will assist in finding a dentist if needed. If I have dental insurance, I authorize my insurance carrier to be billed for services provided. I understand that this treatment may affect future rights and benefits.

X _____ Date ___ / ___ / ___ Relation to Child: _____
Parent/guardian signature (mo / day / year)
 Print name: _____ Day Tel# _____ Mobile# _____