Tooth Fairies, Inc.

Dental Hygienists Dedicated To Prevention

Patient Consent, Patient HIPAA Consent & Health History Form

Tooth Fairies, Inc. follows HIPAA regulations governing patient confidentiality, information available at your request.
I (parent/guardian) understand that occasionally limited information must be transmitted electronically for payment purposes.

Patient Name (Student): First ____________ MI____ Last ____________________ DOB ____ /_____/____
Address: ________________________ City: ____________ Zip _______ Phone/Cell : __________
Parents Email: ________________School: ________________Grade: _____Text Acceptable? Yes No

1. **Has the patient been seen by a dentist on a regular basis for cleanings and checkup?** ☐ Yes ☐ No
   If yes, please list name of dentist: ______________________________________ Date of last visit: ____________
   Has the patient previously been seen by Tooth Fairies Inc.? ☐ Yes ☐ No
2. **A Dental Hygienist will be performing the following oral health services under Public Health Supervision Status.**
   The following services will be provided for your child as needed unless otherwise instructed (twice during the school year):
   - **Dental Cleaning**
   - **Sealant Placement**
   - **Topical Fluoride Treatment**
   - **Oral Evaluation**
   - **Oral Hygiene Instruction**
3. **Health History:** **Please Fold Patient Consent Form for PRIVACY and return to School Nurse.**
   - Please list patient's physician and telephone : ____________________________ Tel.#____________________
   - Does the patient have any known ALLERGIES? ☐ Yes ☐ No **If Yes, Please list:** ____________
     ____________________ ________________________ __________________________
   - Has the patient ever needed antibiotics for dental treatment? ☐ Yes ☐ No

   If Yes, Please take appropriate Medication to be Pre-Medicated prior to treatment

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Please Fold Here For Your Privacy

   - **Does the patient see a cardiologist (heart doctor)?** ☐ Yes ☐ No **If yes, Please list name & telephone.**
     Physician Name: ____ Tel #: ____________________
   - Is the patient taking any medication? ☐ Yes ☐ No If yes, please list: ____________
     ______________________ ________________________ ________________________
   - Please check if patient has been treated for or is under treatment for any of the following:

☐ AIDS	☐ Diabetes	☐ Head Injuries	☐ Mental Disorders	☐ Sinus Problems
☐ Anemia	☐ Epilepsy	☐ Heart Murmur	☐ Nervous Disorders	☐ Stomach Problems
☐ Asthma	☐ Excessive Bleeding	☐ Hepatitis	☐ Radiation Treatment	☐ Tuberculosis
☐ Blood Disease	☐ Fainting	☐ Kidney Disease	☐ Respiratory Problems	☐ Tumors
☐ Cancer	☐ Growths	☐ Latex Allergy	☐ Rheumatic Fever	☐ Ulcers

4. **Are there any patient concerns you would like us to address?** ________________________________
5. **Is your child covered by MaineCare? (Formerly Medicaid and/or Cubcare)?** ☐ Yes ☐ No
6. **MaineCare #:** ______________________________
7. **I DO NOT have Maine Care and I would like to participate in the $42.00 fee for Dental Cleaning, Flouride & Sealants** ☐ Yes ☐ No
8. **I understand the services provided do not take the place of a complete Dental Exam by a Dentist.**

Parent or Guardian Signature: ______________________________ **Date:** ______/______/______

63 Park Street, Mechanic Falls, ME 04256 • (207) 577-4461 • toothfairies_inc@yahoo.com

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