Dental
El Dorado Community Health Centers
(530) 497-5016 • WWW.EDCHC.ORG

El Dorado Smiles
healthy teeth for a healthy life

Health History and Consent Form
(Please complete both sides)

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 □ Black/African American □ Asian □ Native Hawaiian □ American Indian/Alaska Native □ Other Pacific Islander □ More than one race □ 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.

Turn page

Dental
El Dorado Community Health Centers
(530) 497-5016 • WWW.EDCHC.ORG

El Dorado Smiles
healthy teeth for a healthy life

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:________________________________