



ADA American Dental Association®

# Parental Consent, Registration & Health History Form

## Child's Information (*only one child per form*)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>Child's Health History:</b>	<b>Circle all that apply:</b>
<p>■ Does your child have a regular doctor?      <b>YES NO</b></p> <p>■ Has your child been seen in the last 6 months?      <b>YES NO</b> If no, why? _____</p> <p>■ Has your child had an overnight stay in a hospital in the last 6 months?      <b>YES NO</b> If yes, why? _____</p> <p>■ Does your child have any allergies?      <b>YES NO</b> If yes, what? _____</p> <p>■ Does your child take medications?      <b>YES NO</b> If yes, what? _____</p> <p>■ Is there anything else we should know about your child? _____</p>	<p>Asthma      <b>YES NO</b></p> <p>Heart Murmur      <b>YES NO</b></p> <p>Diabetes      <b>YES NO</b></p> <p>Seizures      <b>YES NO</b></p> <p>Heart Disease      <b>YES NO</b></p> <p>Blood Disorders      <b>YES NO</b></p> <p>Please explain: _____ _____ _____</p>
<p>■ Has your child been seen by a dentist before?      <b>YES NO</b></p> <p>■ Is your child covered by a insurance plan? <input type="checkbox"/> <b>NJ Family Care</b>    <input type="checkbox"/> <b>Pay for Service</b>    <input type="checkbox"/> <b>None</b></p> <p>■ HMO: _____</p> <p>■ Insurance Number: _____</p> <p>■ Have you been to a Give Kids A Smile screening in the past?      <b>YES NO</b></p>	<p>I understand that my child may be photographed during this event and I understand that the photos may be used by Give Kids A Smile NJ, the ADA Foundation, or the American Dental Association in future educational and promotional material. All photographs, prints, and reproductions shall be the property of Give Kids A Smile NJ and no compensation will be provided for use of such reproductions.      <b>YES NO</b></p>

## PARENT/GUARDIAN SIGNATURE

I certify that I have read and understood the above questions. The information that I have provided is correct to the best of my knowledge. I will not hold the New Jersey Dental Association or any other participating sites of the *Give Kids A Smile!* program or any member of the staff responsible for any errors or omissions I have made in the completion of this form. I also authorize the doctors, dental staff and dental students to perform the necessary dental services that my child may need including, but not limited to, cleanings, fluoride, sealants, x-rays, anesthesia, pulpotomies, extractions, and fillings.

Name of Parent/Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_