

PRASAD Children's Dental Health Program, Inc is a not-for-profit organization whose mission is to improve the oral health of children.

**IF YOUR CHILD WAS EXAMINED THIS SCHOOL YEAR YOU HAVE ALREADY CONSENTED FOR RE-EXAMINATION**

**CONSENT FORM PLEASE COMPLETE WITH INK SECTIONS 1 – 5 AND RETURN TO THE TEACHER**

**1. Your child's information**

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_  
 Parent's Name \_\_\_\_\_  
 Address \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone (day) \_\_\_\_\_ (evening) \_\_\_\_\_  
 School \_\_\_\_\_ Child's Teacher \_\_\_\_\_ Grade \_\_\_\_\_  
 Date of last dental visit: \_\_\_\_\_

**2. Your child's dental insurance**

- Medicaid ID# \_\_\_\_\_
- Child Health Plus (Wellcare, Fidelis, GHI, Hudson Health Plan, Empire BCBS, MVP) ID # \_\_\_\_\_
- Delta Dental, ID # \_\_\_\_\_
- I do not have dental insurance, and would like to be contacted regarding the Sliding Fee

**3. Health History**

If you don't know or are not sure of the answer to any of these, please call or visit the Mobile Dental Clinic as we cannot provide care without all of this information

- Who is your child's doctor? \_\_\_\_\_ Phone: \_\_\_\_\_
- Is your child taking any medicine(s)? YES NO  
 If yes, what medicine and for what purpose? \_\_\_\_\_
- Has your child ever had any of the following? Please check appropriate box

- |  |  |   |  |
|--|--|---|--|
| Heart Murmur <input type="checkbox"/>            | Radiation Treatment <input type="checkbox"/>       | Sinus Trouble <input type="checkbox"/>      | Cancer or Tumors <input type="checkbox"/>  |
| Epilepsy/Seizure <input type="checkbox"/>        | Asthma <input type="checkbox"/>                    | Emotional Problems <input type="checkbox"/> | Lung Disease <input type="checkbox"/>      |
| Hemophilia <input type="checkbox"/>              | Prolonged Bleeding <input type="checkbox"/>        | Sickle Cell Anemia <input type="checkbox"/> | HIV or AIDS <input type="checkbox"/>       |
| Heart Disease <input type="checkbox"/>           | Liver Disease (Hepatitis) <input type="checkbox"/> | Pneumonia <input type="checkbox"/>          | Artificial Joint <input type="checkbox"/>  |
| Convulsions <input type="checkbox"/>             | Measles <input type="checkbox"/>                   | Jaundice <input type="checkbox"/>           | Hives <input type="checkbox"/>             |
| Blood Transfusion <input type="checkbox"/>       | Chicken Pox <input type="checkbox"/>               | Rheumatic Fever <input type="checkbox"/>    | Physical Handicap <input type="checkbox"/> |
| Diabetes <input type="checkbox"/>                | Hay Fever <input type="checkbox"/>                 | Fainting <input type="checkbox"/>           | Thyroid Problems <input type="checkbox"/>  |
| Anemia <input type="checkbox"/>                  | Arthritis <input type="checkbox"/>                 | Ulcer or Colitis <input type="checkbox"/>   | Kidney Problems <input type="checkbox"/>   |
| Speech/Hearing Problems <input type="checkbox"/> | Bladder Problems <input type="checkbox"/>          | Mumps <input type="checkbox"/>              | Tuberculosis <input type="checkbox"/>      |
| Tonsillitis <input type="checkbox"/>             | Whooping Cough <input type="checkbox"/>            | Eye Problems <input type="checkbox"/>       | Cleft Lip/Palate <input type="checkbox"/>  |

- Are your child's immunizations up-to-date? YES NO
- If no, please explain \_\_\_\_\_
- Has your child ever had an allergic reaction? YES NO

If yes, please explain \_\_\_\_\_

**I understand that in the event there is any change in my child's health status, I will notify your office at the earliest possible time.**

**Required** 4. Parent/Guardian Signature **X**: \_\_\_\_\_ Date \_\_\_\_\_

We will schedule your child during regular school hours. However, if you wish to be present at his/her appointment or if you have any questions, please call (845) 798-2279 or (845) 866-4562 or the Main Office at (845) 434-0376 x 116.

**PLEASE COMPLETELY FILL OUT THIS FORM AND RETURN IT TO THE SCHOOL!**

465 BRICKMAN ROAD, HURLEYVILLE, NY 12747 (845) 866-4562 (845) 798-2279 (845) 434-0376

**CONTINUE →**

## CONSENT AND WAIVER

Child's Name \_\_\_\_\_

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate.

I give consent for my child to receive a dental check-up including x-rays and cleaning. If my child requires any additional dental treatment, the dentist will provide these services which may include any or all of the following: fillings, extractions, crowns, and pulp therapy. I understand that I will be notified before any additional work is started. I also understand that it may not be possible to do all the needed treatment on the mobile dental clinic.

The risks associated with treatment are: accidental biting or scratching of the lip/cheek by the child if local anesthesia "novocaine" is used; temporary discomfort, swelling or bleeding. If no treatment is received, undetected dental/oral disease may lead to pain, swelling, infection or tooth loss.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S INSURANCE COVERAGE, OTHERWISE I WILL BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDING SERVICES PROVIDED TO MY CHILD.

I expressly release PRASAD Children's Dental Health Program, Inc., its directors, officers, agents, representatives, licensees, successors, and assignees from any and all claims (including right of publicity, right of privacy, performance rights and copyrights) which I have or may have arising out of production, reproduction, use, broadcast, exhibition, distribution, or promotion of any portion thereof.

I also consent to having my child's doctor release my child's medical record to PRASAD Children's Dental Health Program, Inc. if my child's health history shows health problems that may affect his/her dental treatment on the mobile dental clinic. In addition, I consent to having PRASAD Children's Dental Health Program release and receive any and/or all information related to my child's health status to and from the Sullivan or Ulster County Department of Family Services and other social service or health care providers.

Recent HIPPA regulations focus on protecting patient confidentiality. One component of the regulations prohibits leaving messages on patient answering machines. I understand that in order to offer a best possible service, it is necessary to utilize answering machines. I authorize PRASAD Children's Dental Health Program and its representative to leave information on my answering machine for services such as reminder for treatment, appointments, confirmation of information or returning your phone call.

I understand that the consent shall remain in effect until I choose to end it, and that I am free to withdraw my consent at any time by written notification to PRASAD Children's Dental Health Program, Inc. I have read and understand this consent form, and have asked questions that I had, and all questions have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may come up during the course of my child's treatment, and that there are no guarantees regarding any treatment results. I understand that I will receive a final report on all treatment received at the clinic.

I hereby authorize the release of any medical /dental information to the Insurance Co., and third party billed, necessary to process my Ins. Claims. I assign the payment of dental benefits payable to: PRASAD Children's Dental Health Program, Inc. 465 Brickman Road, Hurleyville, NY. 12747.

I represent that I am the legal guardian of the above named child and that I have the legal authority to make health care decisions on the child's behalf. If my child receives dental care, I waive any claims, which I may have against the program provider, namely, PRASAD Children's Dental Health Program, Inc., its agents, directors, officers, or employees as a result of the performance of said services.

This consent and waiver shall be binding on my executors, administrators, heirs, legatees and assignees and shall be construed and enforced according to the laws of the State of New York, USA, exclusive of its choice of law rules.

**Required**

**5. Parent or Guardian Signature X** : \_\_\_\_\_ **Date** \_\_\_\_\_

Relationship to Child \_\_\_\_\_