**Family Inc.**

3501 Harry Langdon Blvd. Ste. 150 **Oral Health Services Consent & Release**

Council Bluffs, Iowa 51503

**Phone (712)265-9566 Fax (712)256-9916**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child’s Legal Name:** |  | **Male Female** | **Primary Language:**  |  |
| **Child’s Date of Birth:** |  | **Child’s Age:**  |  | **Translator Needed:** No Yes  | **Language:** |  |
| **Ethnicity:** Not Hispanic or Latino Hispanic or Latino  | **Developmental Delay:** No Yes Explain: |  |
| **Race:** White American Indian/Alaska Native Black/African American Asian Native Hawaiian or other Pacific Islander |
| **Address (street, city, zip):** | **Primary Phone:**  | **Secondary Phone:**  |
| **Email:**  | Home Cell Work Relative | Home Cell Work Relative |
| **Number in Family**  | **Family Monthly Income**  | **Custodial Parent’s Marital Status:** Single MarriedDivorced Separated Parent with Partner Widow |
| **Mother/Guardian Name:****Education Level:**  | **Father/Guardian Name:****Education Level:** |
| **Child’s physician:****Date of last visit:** | **Immunizations Up-to-Date:**Yes No Unsure | **Medical Insurance:** Yes No**Dental Insurance:** Yes No |
| **Child’s dentist:** **Date of last visit:** |  **Medicaid:** Yes No**Medicaid ID Number:** |

I voluntarily authorize **Family Inc.** to release, obtain, or exchange information with the following entities: (dentists, physicians, school, WIC, public health, Head Start) St. Paul’s Lutheran Early Childhood Center. This release does not authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AID-related information.

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**Sign Here**

 **Parent/Guardian signature Date**

\_\_\_\_\_ **YES**, I give permission for my child to receive a dental screening & fluoride varnish application

\_\_\_\_\_ **NO**, I do not give permission for my child to receive a dental screening or fluoride varnish application

* I understand these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program and records created and maintained are property of the Iowa Department of Public Health.
* I understand that these services DO NOT take the place of regular dental checkups at a dental office.
* I understand that Medicaid will be billed for these services (as applicable).
* I understand that any photographs taken may be shared with the Iowa Department of Public health and used for educational and/or promotional purposes.
* I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureaus of Family Health or Oral & Health Delivery System), the Iowa Department of Human Services, or designee.
* I understand that this consent if valid for one year unless withdrawn in writing by the parent/guardian.

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**Sign Here**

 **Parent/Guardian signature Date**

**Please answer the following questions:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is your child currently under the care of a physician? | 🞏 | Yes | 🞏 | No |  Does your child have allergies? | 🞏 | Yes | 🞏 | No |
| Is your child currently taking any medications? | 🞏 | Yes | 🞏 | No |  |  |  |  |  |
| Explain any YES answers: |  |
| Does anyone in the family have a history of tooth decay? | 🞏 | Yes | 🞏 | No |  Does your water have fluoride in it? | 🞏 | Yes | 🞏 | No |
| Does your child brush teeth after meals/before bed? | 🞏 | Yes | 🞏 | No |  Do you use fluoride toothpaste? | 🞏 | Yes | 🞏 | No |
| Who brushes your child’s teeth? | 🞏 | Parent | 🞏 | Child | 🞏 | Both | 🞏 | No brushing |
| Who flosses your child’s teeth? | 🞏 | Parent | 🞏 | Child | 🞏 | Both | 🞏 | No flossing |

**Please circle anything that has prevented you from taking your child to the dentist (circle all that apply):**

 Finding child care for siblings Cost Fear Hours for appointments Language Unpaid bill at office Transportation

 Location of provider No belief in preventive care Provider declines insurance Unaware of need for appointment Nothing

 Other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How do you pay for your child’s dental care (circle all that apply)?** Self Medicaid *hawk-i* Dental insurance Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How often does your child see the dentist?** Every 6 months Once a year Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My child’s most recent dentist visit was within the past** (please circle one): Never 6 months 1 year 3 years 5 years

**Do you have any concerns about your child’s teeth?** No Yes Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child** (please circle all that apply): Use a sippy cup/bottle Drink pop/sugary drinks Eat sugary snacks Revised 4-2014