# Mobile Care Chicago
# Dental Consent Form
# 312-543-5693

**SCHOOL:** _____

**Teacher:** _____ **Grade** _____

State law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. **Please read this form and ask about anything that you do not understand.** We will be pleased to explain it. I hereby authorize and direct Mobile Care Chicago dentists and/or dental auxiliaries to perform upon my child (or legal ward for whom I am empowered to consent) the following checked dental treatment or oral surgery procedure(s)**:**

☐ **Yes,** I would like for my child to receive **ALL SERVICES** offered at his/her school. this includes dental exam, cleaning, fluoride, sealants, x-rays, fillings, pulpotomies, stainless steel crowns, and tooth removal if needed.

☐ **No,** my child receives regular dental care. I do not wish for my child to participate in the program (We encourage you to stay with your family dentist if you have one.)

☐ **Yes** ☐ **No** to photograph and/or videotape of my child during visits for corporate literature and medical, scientific, or educational purposes, provided my child identity is not revealed.

**Patient Information**

Child's FULL Legal Name_____
First Name Middle Name Last Name

Sex: ☐ Male ☐ Female Age _____ Birth Date _____

Do you have legal custody of this child? ☐ Yes ☐ No **If NO, STOP!**

**Forms must be completed by parent or legal guardian**

Parent/Guardian's Name_____

Address _____
Street City State Zip

Email_____

Home Phone_____ Cell Phone_____ Work Phone _____

Does your child have Medicaid/All Kids? ☐ Yes ☐ No If Yes, **I D Number** ___ ___ ___ ___ ___ ___ ___ ___ ___

**Dental History**

Has your child ever been to a dentist? ☐ Yes ☐ No

Does your child have a family dentist? ☐ Yes ☐ No If yes, Dentist's Name and City _____

Has child been seen in the last 12 months? ☐ Yes ☐ No If yes, when _____

What services were performed? _____

Does your child have any dental problems/complaints?

_____

**Has your child been informed by a physician due to a medical condition that he/she needs to take an antibiotic before their dental treatment?** ☐ **Yes** ☐ **No** **If Yes, please explain**_____

## Medical History

Child's Doctor_____ City/State_____ Phone_____

Is child under the care of a doctor now? ☐ Yes ☐ No Ever been hospitalized ☐ Yes ☐ No

If yes, please explain_____ If yes, please explain_____

Is child receiving any medication? ☐ Yes ☐ No Ever had surgery? ☐ Yes ☐ No If yes, why?_____

If yes, list current medications, including over-the-counter and herbal:_____ _____

Is your child allergic to any foods, medications, environmental allergens, or other? ☐ Yes ☐ No

**Please list known allergies**_____

**HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE**

| | | | | |
|---|---|---|---|---|
| **AIDS/HIV** | **Cerebral Palsy** | **Heart Murmur** | **Mental Health** | **Tumors/Growths** |
| **ADD/ADHD** | **Cognitive Disorders** | **Heart Disease** | **Pregnancy** | **Mental Disorders** |
| **Anemia** | **Communication Disorders** | **Hemophilia** | **Respiratory Care/Disease** | **Hearing Problems** |
| **Artificial Heart Valves** | **Developmental Disability** | **Hepatitis** | **Rheumatic Fever** | **Cancer** |
| **Asthma** | **Diabetes** | **Implants** | **Rheumatism/Arthritis** | **Tuberculosis** |
| **Behavioral Disorders** | **Donor Organs** | **Intestinal Disease** | **Seizures** | **Blood Transfusion** |
| **Blood Disorders/Disease** | **Drug/Alcohol Abuse** | **Joint Replacement** | **Sexually Transmitted Diseases** | **Liver Disorder/Disease** |
| **Blood Pressure High** | **Emotional Disorders** | **Kidney Disease** | **Sickle Cell Anemia** | **Fainting/ Dizzy Spells** |
| **Blood Pressure Low** | **Epilepsy** | **LATEX ALLERGY** | **Stomach Disease** | |

**Other:** _____

## Emergency Information

In the event of an emergency, whom should we contact (**other than yourself**)?

Name_____Relationship_____Phone_____

## Consent and Authorization

Although their occurrence is not frequent, some risk and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown from an extracted tooth or gauze packing; injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of sub-acute bacterial endocarditis (head infection) following dental treatment exists; therefore antibiotics will be prescribed before and following treatment, to minimize the risk.

I hereby state that I have read and understand this consent form, that I have been given opportunity to ask questions I might have and that all questions about the procedure(s) have been answered in a satisfactory manner and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. By signing this form I consent and authorize the doctors of Mobile CARE Foundation to furnish dental treatment on my child.

**Signature of Parent/Guardian**_____**Date**_____

**THIS CONSENT IS VALID FOR A PERIOD OF ONE YEAR FROM DATE OF SIGNING**