

Child's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Day Time Phone \_\_\_\_\_ Hm. \_\_\_\_\_

**Health History:** Please, put a check by any of the conditions your child has had:

\_\_\_\_\_ Asthma: Uses an inhaler \_\_\_\_\_

\_\_\_\_\_ Seizures or Convulsions

\_\_\_\_\_ Heart Murmur

\_\_\_\_\_ Latex Allergy

\_\_\_\_\_ Other Allergies \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

Please list any medications \_\_\_\_\_

**I give my consent for my child to receive:**

	<b>YES</b>	<b>NO</b>
• Dental screening exam	_____	_____
• Fluoride treatment	_____	_____
• Cleaning	_____	_____
• Sealants	_____	_____

Parent/Guardian: \_\_\_\_\_

Date \_\_\_\_\_

Has your child been seen in a dental clinic in the last year, yes / no.

There is absolutely no charge to you for your child to participate. However, if you do have DSHS, or dental insurance through your employer, it would help to off set some of the cost of the program if we could bill your child's dental coverage (**you will not be billed if you have a co pay**).

**DSHS** \_\_\_\_\_ Child's name as it appears on the card \_\_\_\_\_

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**Insurance** \_\_\_\_\_ Employer \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Birth date \_\_\_\_\_ Group# \_\_\_\_\_

