Clean and Seal Dental Program Medical History Form

Please complete (in ink) and return to your child's teacher tomorrow

Child's Name: ______________________________ Date of Birth: ____/____/____ ☐ Male ☐ Female

School ______________________________ Grade ____________ Room ________ Teacher ____________

☐ **YES**, I give permission for my child to participate in the Clean and Seal Dental Program.

Please complete and return this form.

☐ **NO,** I do **NOT** give permission for my child to participate in the Clean and Seal Dental Program.

Does your child have any allergies? *If yes, please check all that apply:* ☐ YES ☐ NO

☐ Colophonium ☐ Latex ☐ Tree Nuts ☐ Resins ☐ Food ☐ Artificial Flavoring ☐ Red Dye ☐ Others: __________

General Information:

What language does *child* speak best? _______________ What language does *parent* speak at home? _______________

What is your *child's* race?

☐ American Indian/Alaskan ☐ Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White ☐ Other

Health Information:

***If more room is needed, please attach sheet of paper.*

Does your child see a doctor for regular checkups? ☐ YES ☐ NO

Does your child see a dentist for regular checkups? ☐ YES ☐ NO

If yes, name of the dentist: ______________________________ Date of Last Dental Visit: ______________

Does your child get a cleaning every 6 months? ☐ YES ☐ NO

Is your child taking any medication now? ☐ YES ☐ NO

If yes, please list medications. ______________________________

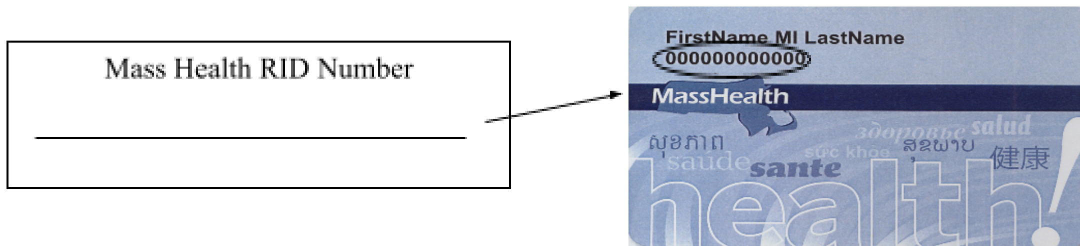
Does your child need to take antibiotics (penicillin) before having dental treatment? ☐ YES ☐ NO

Has your child EVER had an illness or condition? ***If yes,*** *please check all that apply.* ☐ YES ☐ NO

☐ ADD/ADHD ☐ Diabetes ☐ Epilepsy/Seizure ☐ Asthma ☐ Hearth Conditions/ Heart Murmur

Others: ______________________________

If your child has MassHealth / Medical dental insurance, please complete below:



I understand that CLEAN AND SEAL DENTAL PROGRAM may use my child's health information for treatment, payment and health care operations. A copy of the Notice of Privacy Practices will be given upon request. I have read and understand the dental program and services that may be provided to my child. I consent to have my child participate in the program. I authorize the dental program to provide a written summary of the examination-services to an official designated by my child's school. I understand that these services do not substitute for an examination by a dentist and that my child should obtain an examination by a dentist within 90 days, if they have not had one. If needed, the dental program may share your childs dental record with a dentist in the area. In addition, a list of dental offices will be given to your child as well. I understand that my child may continue to receive dental care from any other provider. If I have dental insurance, I acknowledge that this treatment may affect my future rights and insurance benefits, and I authorize my insurance carrier to be billed for any services provided.

x ______________________________ **Date:** ____/____/______ **Relationship to Child:** ______________

Parent/Guardian's Name

______________________________ ______________________ ______________________

Print Name **Phone Number** **Email Address**