Parental Consent, Registration & Health History Form

ADA American Dental Association®

Child's Information (*only one child per form*)

First Name: _____ Last Name: _____

Date of Birth (mm/dd/yy) _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Child's Health History:

- Does your child have a regular doctor? **YES NO**
- Has your child been seen in the last 6 months? **YES NO**

If no, why? _____

- Has your child had an overnight stay in a hospital in the last 6 months? **YES NO**

If yes, why?_____

- Does your child have any allergies? **YES NO**

If yes, what? _____

- Does your child take medications? **YES NO**

If yes, what? _____

- Is there anything else we should know about your child?

_____

- Has your child been seen by a dentist before? **YES NO**
- Is your child covered by a insurance plan?
  ☐ **NJ Family Care** ☐ **Pay for Service** ☐ **None**
- HMO: _____
- Insurance Number: _____
- Have you been to a Give Kids A Smile screening in the past? **YES NO**

Circle all that apply:

Asthma	**YES**	**NO**
Heart Murmur	**YES**	**NO**
Diabetes	**YES**	**NO**
Seizures	**YES**	**NO**
Heart Disease	**YES**	**NO**
Blood Disorders	**YES**	**NO**

Please explain:

_____

_____

_____

I understand that my child may be photographed during this event and I understand that the photos may be used by Give Kids A Smile NJ, the ADA Foundation, or the American Dental Association in future educational and promotional material. All photographs, prints, and reproductions shall be the property of Give Kids A Smile NJ and no compensation will be provided for use of such reproductions. **YES NO**

PARENT/GUARDIAN SIGNATURE

I certify that I have read and understood the above questions. The information that I have provided is correct to the best of my knowledge. I will not hold the New Jersey Dental Association or any other participating sites of the *Give Kids A Smile!* program or any member of the staff responsible for any errors or omissions I have made in the completion of this form. I also authorize the doctors, dental staff and dental students to perform the necessary dental services that my child may need including, but not limited to, cleanings, fluoride, sealants, x-rays, anesthesia, pulpotomies, extractions, and fillings.

Name of Parent/Guardian: _____

Signature: _____ **Date:** _____