Future Smiles Dental Clinic
Treatment Consent Form

The ***Future Smiles Dental Clinic*** **at Wakefield Elementary** provides full service dental care for children who have Medicaid (MCNA or Delta Dental) and those without private insurance. The clinic is located inside of Wakefield Elementary School and sponsored by UALR Children International, Arkansas Children's Hospital, Little Rock School District, Arkansas Department of Health and Heart of Arkansas United Way along with several other organizations. **All of the dental services are at no cost to you and your family.** *(Transportation is available from Bale and Stephens during school hours.)*

To qualify your child must:

- Attend a Little Rock School District school or enrolled in UALR Children International
- **NOT** be an active patient in a dental practice, also known as a dental home.
  (A dental home is a place where your child's oral health care is provided by a licensed dentist on an ongoing basis. It is not our intention to disrupt an ongoing relationship with a Dental Home.)
- **NOT** have private dental insurance, other than Medicaid (MCNA or Delta Dental)

If you would like your child to receive services at *Future Smiles*, please sign below and complete the attached health form. Please return all forms to your child's teacher and we will schedule him/her.

IF YOU WOULD LIKE TO SCHEDULE AN APPOINTMENT AT YOUR CONVENIENCE, CALL 447-6645.

Complete

❑ ***YES. I want to make Future Smiles my child's dental home.***

First Name_____ **Last Name** _____ **Age** ____

Birthday _____ **SSN#**_____ **Sex** *(CIRCLE)* **M or F**

School _____ **Teacher** _____ **Grade** _____

Home/Cell Phone _____ **Work Phone** _____

Email _____ **Contact me by: □ Call □Text □ Email**

Address _____

Medicaid/ARKids 1st Coverage? Yes ○ No ○ Policy # _____

Which Medicaid Dental Insurance does your child have? □ Delta Dental □ MCNA □ None

Brothers/Sisters Names & DOB_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the employees of the UALR Children International Sponsorship Operating Agency ("SOA") and Children International ("CI") to disclose my child's health information to sponsors, business associates, and others affiliated with the sponsorship program as necessary to accomplish the goals of the UALR Children International Sponsorship Program. I also authorize the SOA and Children International to obtain my child's health information from health care providers. I understand that the acquisition of my child's health information and any subsequent disclosures will be for the purpose of educating sponsors about my child and that disclosures will cease upon the end of my child's participation in the program.

I understand that Children International and the SOA have adopted appropriate policies and procedures to prevent the inappropriate disclosure of protected health information that they may receive. I further certify that the UALR Children International Sponsorship Agency and Children International have offered a complete NOTICE OF PRIVACY PRACTICES to me as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby acknowledge that I have either accepted and received a NOTICE OF PRIVACY PRACTICES or that at this time I specifically choose not to receive a full copy of these practices and rights. It is understood that detailed NOTICE OF PRIVACY PRACTICES statements are available and may be obtained at any time from the offices of UALR Children International or Children International and will be furnished to the undersigned upon request.

I understand that executing this authorization is voluntary, participation in the program is not dependent upon executing this authorization, and that I may revoke this authorization at any time. A revocation must be in writing and presented to UALR Children International or Children International. I understand that the revocation will not apply to information that has already been released in response to this authorization and that such information could be subject to an unauthorized re-disclosure by a program sponsor outside the control of the SOA and Children International, which may not be protected by federal privacy rules.

Parent/Legal Guardian Name (Please Print) _____

_____ _____

Parent/Legal Guardian Signature ***I certify that I have been appointed as the Legal Guardian for the child above.** **Date**

Please complete next page →

Future Smiles Dental Clinic
CONSENT/HEALTH HISTORY

Child's Name: _____

Primary Care Provider: _____ **Phone** _____

1) **Is your child under the care of a doctor for any medical problem?** ○ **Yes** ○ **No** ○ **I don't know**
If yes, please explain:_____

2) **Has your child ever had a serious illness or operation?** ○ **Yes** ○ **No** ○ **I don't know**
If yes, please explain:_____

3) **Is your child taking any medications?** ○ **Yes** ○ **No** ○ **I don't know**
If yes, please list all medications (including over the counter and herbal)

Medication	Dose	How often

***Please list additional medications on the back of this page.*

4) **Does your child have any drug/food allergies?** ○ **Yes** ○ **No** ○ **I don't know**
If yes, please explain:_____

5) **Has your child had a history or difficulty with the following? (Check all that apply)**

- ☐ AIDS/HIV Infection
- ☐ Anemia
- ☐ Blood Transfusions/Products
- ☐ Behavioral Problems
- ☐ Breathing Problems
- ☐ Central Venous Line or Port
- ☐ Ear Infections
- ☐ Excessive Bleeding
- ☐ Hepatitis or Liver Problems
- ☐ Hyperactivity or ADD/ADHD
- ☐ Leukemia or Cancer
- ☐ Prosthetic Joints
- ☐ Radiation Treatment
- ☐ Seizures or Convulsions
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Shunt (Brain)
- ☐ Sickle Cell Disease
- ☐ Tuberculosis (TB)
- ☐ Transplants – If Yes, explain: _____
- ☐ Asthma – How often is inhaler used? _____
- ☐ Diabetes – How is it controlled? _____
- ☐ Heart Murmur/Defect (If yes; must have doctor's note before treatment.)
- ☐ Other: Explain_____

I have read and understand:

<u>Drugs and Medication</u> – I understand that antibiotics, analgesics, local anesthesia and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and anaphylactic shock.

<u>Fillings</u> – I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that significant sensitivity is a common after effect of a newly placed filling.

<u>Removal of teeth</u> – I understand that removing teeth does not always remove all the infection, if present and it may be necessary for further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw.

<u>Administration of Nitrous Oxide (laughing gas)</u> - Nitrous oxide/oxygen is perhaps the safest sedative in dentistry. It is nonaddictive, mild, easily taken, then quickly eliminated by the body. Your child remains fully conscious, keeps all natural reflexes, when breathing nitrous oxide/oxygen.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee has been made to me by anyone regarding the dental treatment that I have requested and authorized for my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment and all questions have been answered to my satisfaction.

I hereby agree to release and discharge UALR Children International and Little Rock School District, its directors, officers, employees, agents and assigns, including without limitation volunteer dental professionals who conduct dental care, from any and all liabilities, suits, costs or expenses in any way relating to the participation of the child below in the Future Smiles Dental Program.

I authorize my insurance carrier to send any benefits due on my behalf directly to the Future Smiles Dental Program.

Parent/Guardian Signature _____ **Date** _____

**I certify that I have been appointed as the Legal Guardian for the child above.

If you have any questions/concerns or would like to schedule an appointment, please contact Jolene Perkins or Jennifer Brooks at 447-6645.