JORDAN VALLEY COMMUNITY HEALTH CENTER

PATIENT INFORMATION and CONSENT FORM

TRUDY'S KIDS

The information requested is very important. In order for your child to receive dental care provided by the Jordan Valley staff, you will need to read this form carefully and complete both sides for your child. Please make your answers as complete and accurate as possible. This will help us provide the best possible dental care for your child. This information form becomes part of our permanent record and will be held in strict confidence. If you are unable to complete this form by yourself, please ask for assistance. Please contact your school nurse or the Jordan Valley Dental Clinic at **417-831-0150 with any questions you may have. Thank you.

1. **Name of Patient_____ Sex M / F**
2. **Age_____ Date of Birth_____/_____/_____ Weight _____ Social Security# _____**
3. **Grade_____ School patient attends _____**
4. **Is your Child a Bus rider? _____ Pick up? _____ and/or Walk home? _____**
5. **Home address: Street_____**

   City_____ State _____ Zip _____
6. **Telephone numbers: Home_____ Cell_____ Work_____**
7. **Does the child have private dental insurance? YES _____ NO _____**
8. **Does the child have Medicaid/MO HealthNet? YES _____ NO _____ Medicaid Number _____**

Name of Parent/Legal Representative: _____

Date of Birth:_____/_____/_____ Relationship to patient: _____

Reason(s) for seeking dental care for you child:

Routine check-up_____ Toothache_____ Other(specify)_____

Has your child seen a dentist before? Yes _____ No_____

If yes, date of last visit and treatment received? _____

Any unpleasant experiences in a dental office? _____

CONSENT AND AGREEMENT:

It is our policy to ensure that you are informed of the treatment that we plan to provide and to obtain your written informed consent before any dental treatment is provided for you child. I have been informed there are some risks inherent in all dental procedures including the administration of local anesthesia. I am aware that the risks are essentially the same as those procedures performed in a private dentist's office (for example, possible allergic reaction to anesthetic drug, possible accidental cuts or abrasions). Further, I certify that I understand and agree to the conditions set forth above. I also understand I am free to ask any questions regarding the procedure and risk involved.

I hereby give consent to the Jordan Valley Dental Clinic staff to perform on _____(child's name) those procedures and treatments, including local anesthesia, which are deemed necessary with the exception of

_____.

This treatment consent will be in effect for the year July 1, 2020 to June 30, 2021.

Signature_____ Date_____

Please note the federal government requires us to ask you for this information and it will be used for government reporting purposes only. Your name nor any other identifying information will ever be disclosed and we will not use this information for any other purpose.
Please circle your family size and the range of your annual income.

Family Size	A	B	C	D
1	$0 - $ 11,170	$ 11,171 - $ 16,755	$ 16,756 - $ 22,340	$ 22,341 or greater
2	$0 - $ 15,130	$ 15,131 - $ 22,695	$ 22,696 - $ 30,260	$ 30,261 or greater
3	$0 - $ 19,090	$ 19,091 - $ 28,635	$ 28,636 - $ 38,180	$ 38,181 or greater
4	$0 - $ 23,050	$ 23,051 - $ 34,575	$ 34,576 - $ 46,100	$ 46,101 or greater
5	$0 - $ 27,010	$ 27,011 - $ 40,515	$ 40,516 - $ 54,020	$ 54,021 or greater
6	$0 - $ 30,970	$ 30,971 - $ 46,455	$ 46,456 - $ 61,940	$ 61,941 or greater
7	$0 - $ 34,930	$ 34,931 - $ 52,395	$ 52,396 - $ 69,860	$ 69,861 or greater
8	$0 - $ 38,890	$ 38,891 - $ 58,335	$ 58,336 - $ 77,780	$ 77,781 or greater
9	$0 - $ 42,850	$ 42,851 - $ 64,275	$ 64,276 - $ 85,700	$ 85,701 or greater
10	$0 - $ 46,810	$ 46,811 - $ 70,215	$ 70,216 - $ 93,620	$ 93,621 or greater

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

- ❑ Abdominal pain ____/____/____
- ❑ ADD / ADHD ____/____/____
- ❑ Allergies ____/____/____
- ❑ Anemia ____/____/____
- ❑ Anxiety ____/____/____
- ❑ Arthritis ____/____/____
  Location:_____
- ❑ Artificial heart valve ____/____/____
- ❑ Asthma ____/____/____
  Rescue inhaler Yes/No
- ❑ Atrial fibrillation ____/____/____
- ❑ Autism/Asperger's ____/____/____
- ❑ Blood clots ____/____/____
- ❑ Breastfeeding ____/____/____
- ❑ Bronchitis ____/____/____
- ❑ Bruise easily/ ____/____/____
  Excessive bleeding
- ❑ Cancer ____/____/____
  Type: _____
- ❑ Chemotherapy/ ____/____/____
  Radiation Treatment ____/____/____
- ❑ Chest Pain ____/____/____
- ❑ Chicken pox ____/____/____
- ❑ Cognitively ____/____/____
  Developmentally
  Disabled
- ❑ Cold sores / ____/____/____
  Fever blisters
- ❑ Concussion ____/____/____
- ❑ Convulsions / Epilepsy ____/____/____
- ❑ Cortisone/steroid ____/____/____
  Medicine
- ❑ Coronary artery disease ____/____/____
- ❑ Crohn's disease ____/____/____
- ❑ Cystic Fibrosis ____/____/____
- ❑ Depression ____/____/____
- ❑ Diabetes ____/____/____
- ❑ Dizziness/Fainting spells ____/____/____
- ❑ Down's syndrome ____/____/____
- ❑ Emphysema ____/____/____
- ❑ Gallbladder disease ____/____/____
- ❑ Hearing problems ____/____/____
- ❑ Heart attack ____/____/____
- ❑ Heart murmur ____/____/____
  Pre- Med Y or N
- ❑ Heart trouble/disease ____/____/____
- ❑ Heartburn ____/____/____
- ❑ Hemophilia ____/____/____
- ❑ Hepatitis ____/____/____
  Type:_____
- ❑ Herpes ____/____/____
- ❑ High blood pressure ____/____/____
- ❑ High Cholesterol ____/____/____
- ❑ History of endocarditis ____/____/____
- ❑ HIV ____/____/____
- ❑ Irregular heart beat ____/____/____
- ❑ Irritable bowel disease ____/____/____
- ❑ Jaw pain ____/____/____
- ❑ Kidney disease ____/____/____
- ❑ Learning disability ____/____/____
- ❑ Liver disease ____/____/____
- ❑ Malignant Hyperthermia ____/____/____
- ❑ Migraine headaches ____/____/____
- ❑ Mitral valve prolapse ____/____/____
- ❑ MRSA infection ____/____/____
- ❑ Osteoporosis ____/____/____
- ❑ Pneumonia ____/____/____
- ❑ Pregnancy ____/____/____
- ❑ Psychiatric care ____/____/____
- ❑ Radiation to head/neck ____/____/____
- ❑ Sinus trouble ____/____/____
- ❑ Spina bifida ____/____/____
- ❑ STD's ____/____/____
  Type: _____
- ❑ Stomach ulcer ____/____/____
- ❑ Stroke ____/____/____
- ❑ Taken or taking ____/____/____
  bone density
  Medications
- ❑ Taken Phen-Fen ____/____/____
  Or Redux
- ❑ Taking blood thinners ____/____/____
- ❑ Thyroid disease ____/____/____
- ❑ Trauma to head/neck ____/____/____
- ❑ Vision problems ____/____/____

Other:

_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____

Name/DOB_____

Surgical History

Please check all that apply.

❑ Angioplasty	____/____/____	❑ Heart surgery	____/____/____	❑ Other Hospitalizations/ Surgeries	
❑ Congenital heart Conditions	____/____/____	❑ Heart transplant	____/____/____	_____	____/____/____
❑ Ear tubes	____/____/____	❑ Heart valve problems		_____	____/____/____
❑ Family History of problems with anesthesia	____/____/____	❑ Hip replacement	____/____/____	_____	____/____/____
❑ Heart Stent	____/____/____	❑ Knee replacement	____/____/____	_____	____/____/____
		❑ Other joint replacement	____/____/____	_____	____/____/____
		❑ Tonsil/adenoid removal	____/____/____	_____	____/____/____

Pediatric History

Parents/siblings with cavities?	❑ Yes	❑ No
Fluoride in water?	❑ Yes	❑ No
Uses a sippy cup?	❑ Yes	❑ No
Child is put to bed with a bottle or sippy cup?	❑ Yes	❑ No
Fluoride toothpaste used?	❑ Yes	❑ No
Uses a pacifier?	❑ Yes	❑ No
Sucks thumb/finger?	❑ Yes	❑ No
Times per day teeth are brushed	_____	

Social History

Do you use tobacco? ❑ Yes ❑ No ❑ Former Type of tobacco used? _____/_____
Packs per day? _____ Years smoked? _____ Year Quit? _____

Do you drink alcohol? ❑ Yes ❑ No ❑ Former Year Quit? _____
How much per week? _____ Last Drink? _____

Drug Use Abuse

Have you ever used illegal drugs? ❑ Yes ❑ No ❑ Formerly Type _____

Medications/Herbal Supplements

Medication ❑ No medications

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Allergies

Allergy ❑ No known allergies

1.	4.
2.	5.
3.	6.

Birth History

Maternal illness / complications ❑ Yes ❑ No
Type: _____
Premature Birth ❑ Yes ❑ No
Birth weight ____lbs ____oz

Stayed in NICU ❑ Yes ❑ No
Intubation in NICU ❑ Yes ❑ No
Feeding history ❑ Breast ❑ Bottle ❑ Both