TeamSmile®
Dental and Sports Professionals Teaming Up To Provide Free Dental Healthcare

Patient Consent for Dental Treatment and Health History

Please complete this form, front and back, and sign as parent or guardian for your child on front and back ("patient").
TeamSmile will provide free dental care and preventative care including, but not limited to, diagnostic exams, x-rays, cleanings, sealants, fillings, extractions, pulpotomies, crowns, and silver diamine fluoride (SDF) while educating the patient on the value of a life-long commitment to oral health care.

Information About The Patient To Be Completed by Parent or Guardian

School or Organization Patient is With: _____
Patient's Name:_____
Age: _____ Patient's Date of Birth: _____Patient's Gender: Male _____ Female_____
Home Address: _____
City: _____ State: _____ Zip: _____
Medicaid Eligible: Yes_____No_____
Race/Ethnicity (circle all that apply) American Indian/Alaska Native Asian Black/African American Native Hawaiian/other Pacific Islander Hispanic/Latino White Other_____
Language(s) spoken in home_____

Name of Parent/Guardian: _____ Relationship to Patient: _____
Email: _____ Cell/Mobile Phone:_____

IN CASE OF EMERGENCY CONTACT on the day of service:
First Name: _____ Last Name: _____
Preferred Phone: _____ Alternative Phone: _____

For each question, indicate consent (yes) or no consent (no) by placing the appropriate "x" in either of the boxes below.

Yes	No	
		Preventive and Diagnostic Services: teeth cleaning, oral hygiene instructions, sealants, fluoride treatment and screening
		Restorative Services: fillings, stainless steel crowns, pulpotomy with xrays. Local anesthesia may be used for these procedures
		Extraction of Primary (Baby) Teeth: Removal of primary teeth that cannot be restored through other treatments with xrays. Local anesthesia may be used for this procedure
		Extraction of Permanent Teeth: Removal of permanent teeth that cannot be restored through other treatments with xrays. Local anesthesia may be used for this procedure.
		Silver Diamine Fluoride (SDF) a liquid that helps stop tooth decay with xrays. SDF is applied every 3, 6 or 12 months. A small amount will be applied to the decayed tooth area – no eating or drinking for 60 minutes after application and do not brush the tooth until the following morning. The decayed area will statin black permanently. **Healthy tooth structure will not stain**. I should not be treated with SDF if 1) I am allergic to silver. 2) There are painful sores or raw areas on my gums or anywhere in my mouth

Benefits of receiving SDF: Helps stop tooth decay. Fast. Do not need to numb teeth. Does not hurt.

Risks of receiving SDF: The affected area will stain black permanently (See Photo). This means SDF is working. Tooth-colored fillings and crowns may discolor if SDF is applied to them. After SDF treatment, a filling or crown might still be needed. Allergic reaction. Risk that the procedure will not stop the decay. Not every cavity can be treated with SDF

I understand the patient will not receive dental treatment unless my consent is given. I further understand that no promise, guaranty or warranty has been made regarding the results of any treatment or procedure. I understand that there are inherent risks in any dental treatment, including but not limited to swelling, bruising, allergic reaction, changes in pain, etc. By signing below, you agree to NOT hold TeamSmile or its volunteers liable for performing any preventative care or dental treatment diagnosed and recommended by licensed dental professionals. TeamSmile's mission is to provide your patient free dental and preventative care. You may revoke this consent at any time, except to the extent it has been relied upon, by emailing a written request to: info@teamsmile.org. I attest that I understand the information on this form and that I have been given the opportunity to ask any questions that I may have.

Name of Parent/Guardian (Printed) _____

Signature _____ Date _____

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Health History
Form Must be Completed for Treatment

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your patient may have, or medication that your **patient may be taking or has taken**, could have an important interrelationship with the dentistry your patient will receive. Thank you for answering the following questions.

Is the patient under a physician's care now?	□ Yes □ No	If yes, explain: _____
Is the patient taking any medications?	□ Yes □ No	If yes, explain: _____
Has your patient been hospitalized due to a dental emergency?	□ Yes □ No	If yes, explain: _____
Has your patient ever seen a dentist before?	□ Yes □ No	
Does your patient presently have a dental home?	□ Yes □ No	
Is your patient having any dental pain now?	□ Yes □ No	

Is there anything else we should know about the health of your patient? List: _____

Has the patient had a history of or had difficulty with the following? Check any that apply

□ ADD/ADHD	□ Cerebral Palsy	□ Eating Disorders	□ High Blood Pressure	□ Sinus Problems
□ AIDS/HIV	□ Chronic ear infections	□ Epilepsy/seizures	□ Kidney Disease	□ Stomach/Intestinal Disorders
□ Anemia	□ Cold sores/Herpes	□ Excessive Bleeding	□ Liver Disease	□ Tuberculosis
□ Asthma	□ Convulsions	□ Fainting	□ Migraines	
□ Autism	□ Diabetes Type I	□ Hearing Problems	□ Mono	
□ Cancer	□ Diabetes II	□ Heart Problems	□ Respiratory Problems	

Has your patient ever had any serious illness not listed above? □ Yes □ No If yes, please explain: _____

Is the patient allergic to any of the following? □ No allergies

□ Aspirin □ Penicillin □ Codeine □ Metal □ Silver □ Latex □ Local Anesthetic □ Other _____

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform TeamSmile of any changes to the patient's medical status.

Signature of Parent/Guardian_____ **Date:**_____

Authorization for Release of Protected Health Information

By signing this document, you are allowing TeamSmile staff to give or receive your child's health care records to other health care providers, or child agencies to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care entity that TeamSmile staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

I hereby authorize: TeamSmile 2000 Swift Street North Kansas City, MO 64116 Phone: (816)595-8326 to receive from or release to the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Signature of Parent/Guardian_____ **Date:**_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____

Photographic/Media Release

I voluntarily and knowingly authorize TeamSmile to take Photographs of me for publicity purposes on behalf of TeamSmile. "Photographs" may include video or still photography, as well as related prints, negatives, computer graphics, or electronic images.

I understand that I can request that Photographs of me not be taken or used at any time; however, such request will not have any effect on Photographs that have already been taken of me and permissibly used.

I hereby give TeamSmile the absolute right and permission to publish or otherwise use, in part or in whole, my name, story, health information, and any Photographs taken of me pursuant to this Release, for marketing and public relations purposes, including but not limited to: Website, Brochures/Flyers, Newsletters, and Social Media, such as Facebook.

I acknowledge that any Photographs that are taken of me pursuant to this Release will be the sole property of TeamSmile. I understand that I will not have the right to receive a copy, inspect, or approve any Photographs prior to the uses authorized above. I understand that consenting to permit the use of my name, story, health information, and Photographs is of no direct benefit to me. I waive any and all rights that I may have to any claims for payment or royalties in connection with the use and disclosure of such information and Photographs. I, along with my heirs, representatives, and beneficiaries, will hold TeamSmile harmless from and against any claim for injury or compensation resulting from the use of my information and Photographs in accordance with this Release.

I acknowledge that if TeamSmile discloses my information and or Photograph to a media outlet pursuant to my authorization, TeamSmile has no control over how the media outlet uses or presents my information or Photograph. As such, I hereby release and agree to hold TeamSmile harmless from any and all liability arising from a media outlet's use of my information or Photograph.

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➡ **Signature of Parent/Guardian**:_____