TUFTS COMMUNITY DENTAL PROGRAM

Consent for your child to be seen by the TUFTS DENTAL HYGIENIST

____

(Name of Child)

_____ **YES,** I give permission for my child:

_____ **NO,** I do not give permission; reason for refusal:

____

To receive all of the dental services provided by the Tufts Community Dental Program Hygienist. I understand that preventive services may include any or all of the following: **Oral Hygiene Instruction, Oral Health Screening, Dental Cleaning, Topical Fluoride Application and Preventive Sealants.**

Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's treatment. Most children do not encounter any difficulties with their treatment. There are several behavioral management techniques such as Tell-Show-Do and positive reinforcement that are used to gain the cooperation of child dental patients. If your child indicates any resistance to dental treatment, we would discontinue the treatment so as not to upset your child. In rare instances, a child may experience some discomfort, pain or bleeding.

I understand that this consent will stay in effect while my child attends this school and that it is my responsibility to inform the dentist, dental hygienist and/or the school nurse of any changes in my child's medical history. **I also agree to the confidential release of information to my insurance carriers for the purpose of billing and corroboration of information.**

____

Signature of Parent or Legal Representative

____

Printed Name, Relationship to the Child and Date

Phone: (413) 467-9013
Email: nancy.johnson@tufts.edu

ORAL HEALTH IMPACT PROJECT

Consent for your child to be seen by the OHIP DENTIST

____

(Name of Child)

_____ **YES,** I give permission for my child:

_____ **NO,** I do not give permission; reason for refusal:

____

To be examined and/or treated by the dentists representing the Oral Health Impact Project.

I understand this treatment may include any or all of the following:

Dental Exam and Diagnosis, X-Rays, Dental Cleaning, Topical Fluoride Application, Preventive Sealants and Restorative Dentistry.

I also give permission for my child to have fillings with possible application of local anesthetic xylocaine most commonly called "Novocaine".

I understand that this consent will stay in effect while my child attends this school and that it is my responsibility to inform the dentist, dental hygienist and/or the school nurse of any changes in my child's medical history.

I understand that my child may be referred to an outside dental office or community health center dental clinic if necessary for further treatment.

I also agree to the confidential release of information to my insurance carriers for the purpose of billing and corroboration of information.

____

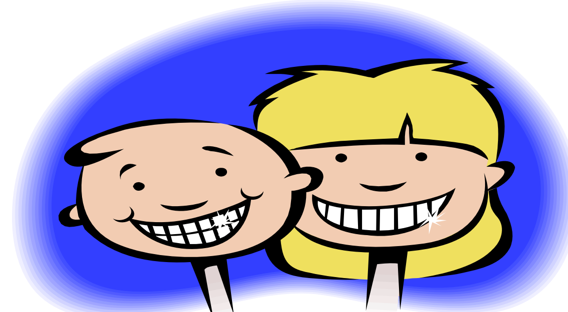
Signature of Parent or Legal Representative

____

Printed Name, Relationship to the Child and Date

Phone: (866) 916-OHIP (6447)
Email: information@ohip.us

ORAL HEALTH ACROSS THE COMMONWEALTH



Great News!!!

Your child can receive DENTAL SERVICES at school.

THE TUFTS UNIVERSITY SCHOOL OF DENTAL MEDICINE DENTAL HYGIENIST

offers:

- Oral Hygiene Instruction
- Oral Health Screening
- Dental Cleaning
- Fluoride Application
- Preventive Sealants

THE ORAL HEALTH IMPACT PROJECT DENTIST

offers:

- Dental Exam and Diagnosis
- Dental X-Rays
- Dental Cleaning
- Fluoride Application
- Preventive Sealants
- Restorative Dentistry

PLEASE SIGN BOTH PANELS TO RECEIVE SERVICES FROM THE DENTIST AND DENTAL HYGIENIST.

PATIENT INFORMATION

School Name   Grade   Room Number

Child's First Name   Last Name

Address: Number   Street   Apt.

City   State   Zip

Date of Birth

Social Security Number

Gender: _______ Female _______ Male

Parent or Guardian Name

Relationship to Child

Home Phone

Work or Cell Phone

Has your child been to the dentist in the past year? _____ **yes** _____ no **If yes,** dentist name:

Race (Optional):
☐1 White; ☐2 Black/African American
☐3 Asian; ☐4 Native Hawaiian/Pacific Islander
☐5 American Indian/Alaska Native;
☐6 Hispanic; ☐7 Unknown; ☐8 Multi-Racial

INSURANCE INFORMATION

Section I – Mass Health

Mass Health RID # (10 digits-next to child's name)

Mass Health Card # and Sequence # (01, 02 etc.)

CMSP # and Subscriber Name

Section II – Dental Insurance Information

Dental Insurance Company Name

Subscriber's Name

Subscriber's Birth Date

Subscriber's Social Security Number

Subscriber's ID

Group Policy Number

Please send a copy of any Mass Health or Private Insurance Cards to school for your child's first appointment.

If your child has Mass Health and/or dental insurance, the insurance company will be billed directly for the dental services.

MEDICAL INFORMATION

Physician's Name

Physician's Address

Physician's Phone

Does your child need to be pre-medicated for dental treatment? _____ **yes** _____ no

If **yes**, please explain: ______________________

Allergies (specify): ___________________________

Medications (specify): _________________________

Allergies to Medications (specify): ______________

Does your child have a developmental disability? _____**yes** _____ no If **yes**, please explain: ________

Has your child ever had any of the following?
Please check all that apply and explain below:

YES	NO		YES	NO	
☐	☐	AIDS/ASC/HIV	☐	☐	Hepatitis
☐	☐	Asthma	☐	☐	Herpes
☐	☐	Birth Defects	☐	☐	High Blood Pressure
☐	☐	Blood Disorders	☐	☐	Kidney Disorder
☐	☐	Congenital Heart Disease	☐	☐	Latex Allergy
☐	☐	Cytomegalovirus	☐	☐	Pins/Broken Bones
☐	☐	Diabetes	☐	☐	Rheumatic Fever
☐	☐	Epilepsy/Seizures	☐	☐	Stomach/GI Disorder
☐	☐	Fainting/Dizziness	☐	☐	Tuberculosis
☐	☐	Heart Disease/Murmur	☐	☐	Venereal Disease
☐	☐	Other/**Explain**:			

PLEASE BE SURE TO COMPLETE ALL SECTIONS ON THE FRONT AND BACK SIDES OF THIS FORM.