



Dakota Smiles Patient Information Form

You are required to bring your child's immunization records.

Please fill out this form completely. If you have questions, please ask a Dakota Smiles staff member. Thank You!

Patient Name _____ **Birth Date** (mm/dd/yyyy) _____

Patient's Social Security Number _____ - _____ - _____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Ethnicity: Which one of these groups would you say best represents the patient's race? (circle one)
 White Black or African American Asian American Indian Hispanic/Latino Other _____

Home Address _____
 Street/ P.O. Box City State Zip

Phone Numbers: Home (_____) _____ Work (_____) _____
 Cell (_____) _____

Parent Name _____ Note: Dental visits should start at age 1.

Emergency Contact: Person to contact in case of an emergency
 Name _____ Relation to patient _____ Phone (_____) _____

Income: Which of these best represents your annual household income? (circle one)
 Less than \$10,000 \$10,000-20,000 \$20,000-30,000 More than \$30,000

Household Size: How many children less than 21 years of age live in your household? _____

Dental History	Yes	No	Please explain answers
Is this the patient's first dental visit?			
If no, how long has it been since the patient last saw a dentist?			
Does the patient have to travel more than 85 miles for dental appointments?			
Has the patient had any unpleasant experiences in a dental or medical office?			If "yes" please explain.
Does the patient brush daily?			If "yes" how often?
Does the patient floss?			If "yes", how often?
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			How many does the patient drink per day?
Does the patient drink milk daily?			How many times per day?
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle – school work both How many times?
Has the patient visited the ER/hospital for dental pain in the last year?			How many times?

Reason for Visit: Check any that apply (✓)

First examination
 Accident to teeth
 Routine exam
 Other (specify) _____
 Toothache
 Bleeding around the teeth
 Teeth appearance _____
 Mouth pain/face swelling
 Couldn't afford dental care
 Couldn't get appointment anywhere else

Medical History

Past or Current Dentist _____ Patient's Current Physician _____

Medical History	Yes	No	Please Explain "yes" Answers
Does the patient have a current medical condition?			
Has the patient been diagnosed with autism?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Is the patient currently protected by immunization (shots) against DPT (diphtheria, whooping cough, tetanus) polio, measles, mumps, and German Measles (rubella)? Records required.			
Does the patient have any special needs that would require special arrangements for dental care?			

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mono |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Epilepsy/ seizures | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stomach/ intestinal disorders |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic eye infections | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Measles | |

For immunization purposes:

Could the patient be pregnant

Please explain "yes" answers: _____

Behavioral Issues	Yes	No	Please Explain "yes" answers
Do you think the patient uses tobacco products (cigarettes, chewing tobacco)?			
Does anyone smoke in the household?			
Do you think the patient is using alcohol and/or drugs?			
Have you noticed any major changes in the patient's behavior, withdrawal, anxiety, grades, moods, friendships, or leisure activities?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided. **Must provide a copy of your dental insurance card if applicable.**

Medicaid/ SCHIP **Private DENTAL Insurance** (please provide copy of card) **IHS** **None**
 Medicaid Number/ Policy Number _____ Reservation (IHS) _____

Dental Ins. Name: _____ policy # _____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

 **Parent/ Legal Guardian signature** _____ Date _____

Dakota Smiles Mobile Dental Program Treatment Consent and Agreement Form



I authorize and request the performance of dental services for my child _____
(child's name)

This treatment may consist of dental x-rays, diagnosis, topical fluoride application and other preventive measures as well as restorations, extractions and minor orthodontic (dental) procedures as recommended by the Dakota Smiles Program staff. I understand that the Dakota Smiles dentists will use restorative treatment and behavior management that is reasonable and necessary.

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)

give my consent for the use of local anesthetics and nitrous oxide as deemed appropriate by the Dakota Smiles dentists in performing the recommended treatment(s) with the exception of _____ (write **NONE** in this blank if you give permission for all dental procedures prescribed).

I consent that _____, who is under the age of eighteen years, may participate in the dental services
(print child's name)
provided by the Dakota Smiles program, and consent that their dentists and other agents and employees may furnish to Dakota Smiles employees and/or authorized organizations all information concerning the child's case history, dental examinations, written reports (and any accompanying photographs) with respect to the dental examination and the exam results. An authorized organization is one approved by the Dakota Smiles Program and the Delta Dental Philanthropic Fund.

I consent and authorize the Dakota Smiles Program to file and collect South Dakota Medicaid/SCHIP reimbursement for dental and immunization services performed and the recording of immunizations on the South Dakota Immunization Information System (SDIIS). I also certify that I understand and agree to the conditions described above.

Are you currently the legal guardian for this child?	YES	NO
Can you sign for medical treatment?	YES	NO
I have been informed of the risks involved with dental treatment	YES	NO

Parent/guardian name _____ (please print)

Relationship to child _____

Signature _____ Date _____



HIPPA Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

I, _____
(parent/legal guardian name)

have received a copy of the Dakota Smiles Program's Notice of Privacy Practices.

Parent/legal guardian signature _____ Date _____

Note: This authorization is valid for six years from date of signature unless revoked in writing prior to that date. This authorization may be revoked by writing to: Dakota Smiles Mobile Dental Program, PO Box 1157, Pierre, SD 57501.

Dakota Smiles Mobile Dental Program

Authorization of Release of Protected Health Information

By signing this document, you are allowing the Dakota Smiles staff to give or receive your child's health care records to other health care providers, SDIIS 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 provider that the Dakota Smiles 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, SDIIS, etc.) for record keeping purposes.

Patient's Name _____ Social Security Number _____ - _____ - _____

I hereby authorize:

Dakota Smiles Mobile Dental Program
C/o Delta Dental Philanthropic Fund
PO Box 1157, Pierre, SD 57501, 605-224-7345

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.

Name of parent/legal guardian _____
(please print)



Parent/legal guardian signature _____ Date _____

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



Photo Consent and Release

I consent to the use of pictures, video or audio recordings of myself or my child for program promotion, including print, audio, video and web promotion. I also agree that any writing or other material in connection with the Dakota Smiles Mobile Dental Program (including any correspondence from our family to Ronald McDonald® House Charities of South Dakota, the Ronald McDonald® Care Mobile the Delta Dental of South Dakota/Delta Dental Philanthropic Fund and other) may be used in promotional materials.



Signature of parent/legal guardian _____ Date _____

The Ronald McDonald® Care Mobile is made possible by a grant from Ronald McDonald® House Charities, Inc., ("RMHC"), a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald® Care Mobile or any of the medical or dental activities conducted therein.