BOYS & GIRLS CLUB OF ALBANY
DENTAL CLINIC

PATIENT INFORMATION

PATIENT NAME_____ **DATE OF BIRTH**_____ **GRADE**_____

PARENT/LEGAL GUARDIAN NAME_____

ADDRESS_____ **CITY**_____ **ZIP**_____

PHONE NUMBERS: MOBILE_____ **HOME**_____ **WORK**_____

EMERGENCY CONTACT (other than parent/guardian):

NAME_____ **RELATIONSHIP TO PATIENT**_____

PHONE_____

ETHINICITY: *White Hispanic/Latino African American Asian American Indian Other*_____

INCOME: *$0-12,000 $12,001-17,000 $17,0001-25,000 More than $25,000*

HOW MANY CHILDREN UNDER THE AGE OF 18 LIVE IN OUR HOUSEHOLD? _____

Can we take photos of your child in our clinic for marketing purposes or display? YES NO

DENTAL HISTORY

IS THIS THE PATIENT'S FIRST DENTAL VISIT? NO YES

IS THE PATIENT IN DENTAL PAIN? NO YES Where is the pain located? _____

HOW MANY TIMES PER DAY DOES THE PATIENT BRUSH? _____ **FLOSS?**_____

HAS THE PATIENT EVER HAD AN UNPLEASANT DENTAL EXPERIERENCE? YES NO

TREATMENT CONSENT

I, _____, as the parent/legal guardian of _____ authorize the performance of dental services for this child. This treatment may consist of dental x-rays, diagnosis, preventive services including cleanings and fluoride, extractions and restorations as prescribed by our licensed dental professionals. I understand the Dental Clinic Dentists will use local anesthetic when necessary for treatment.

I consent that this child may receive dental services provided by the Dental Clinic and consent that their dentists and other agents/employees may furnish to the Dental Clinic employees and/or authorized organizations all information concerning the child's case history, dental examination, written notes, necessary radiographs with respect to the dental examination and results.

I consent and authorize the Dental Clinic to file and collect any insurance payment through Oregon Health Plan (OHP) for reimbursement for dental services performed.

As the parent/legal guardian of this child I have been informed and understand the risks and benefits of dental treatment that may be performed in our Dental Clinic. I have also been informed of alternatives or risks if I do not consent to recommended treatment.

PRINTED Parent/Legal guardian name _____

SIGNED Parent/Legal guardian name _____ Date_____

MEDICAL HISTORY

CURRENT PHYSICIAN_____ PHONE NUMBER_____

DOES YOUR CHILD TAKE ANY MEDICATIONS CURRENTLY? YES NO

PLEASE LIST NAMES OF ALL MEDICATIONS YOUR CHILD IS TAKING:

_____

DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES? YES NO

PLEASE LIST KNOWN ALLERGIES: _____

DOES YOUR CHILD HAVE ANY CURRENT HEALTH CONDITIONS WE SHOULD BE AWARE OF? YES NO

PLEASE EXPLAIN ANY CONDITIONS:_____

CURRENT WEIGHT:_____

DOES THE CHILD HAVE ANY OF THE FOLLOWING: (please circle)

Anemia	Convulsions	Excessive Bleeding	Latex Allergy	Sinus Problems
Asthma	Chicken Pox	Fainting	Liver Disease	Sore Throats
AIDS/HIV	Chronic Ear Infections	Hearing Problems	Measles	Stomach Problems
Birth Defects	Chronic Eye Infections	Heart Problems	Mental Health Issues	Tuberculosis
Cancer	Diabetes	Hepatitis	Mumps	Other:
Cerebral Palsy	Epilepsy/seizures	Kidney Disease	Rheumatic Fever	_____

For female patients, is there a chance you could be pregnant? YES NO

DOES YOUR CHILD HAVE ANY OTHER MEDICAL ISSUES THAT NEED FURTHER EXPLINATION? YES NO

_____

_____

_____

To the best of my knowledge all information I have provided regarding the patients' medical history is true.

NAME:_____ DATE:_____

BOYS & GIRLS CLUB OF ALBANY
DENTAL CLINIC

AUTHORIZATION of RELEASE of PROTECTED HEALTH INFORMATION

By signing the document, you are allowing the Boys & Girls Club of Albany's Dental Clinic staff to give or receive from other health care providers or child agencies your child's dental health records to provide the best care possible for your child. The records may be sent to another dentist, dental specialist, or other health care provider that the Boys & Girls Club of Albany's Dental Clinic staff recommends further treats your child. The information may also be shared with an agency that your child is affiliated with for record keeping purposes.

PATIENT'S NAME: _____

I hereby authorize the Boys & Girls Club of Albany's Dental Clinic 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.

PRINTED Name of Parent/Legal Guardian: _____

Parent/Legal Guardian's Signature: _____

Please list any providers or agencies you DO NOT want your child's records to be released to:

_____

HIPAA

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES

"You may refuse to sign this Acknowledgement"

PATIENT'S NAME: _____

I, (PRINTED parent/legal guardian's name) _____, have read and/or received a copy of the Boys & Girls Club of Albany Dental Clinic's Notice of Privacy Practices.

Parent/Legal Guardian's Signature: _____ Date: _____

DENTAL CLINIC APPOINTMENT POLICY

We are a clinic staffed by mostly volunteers who are here to help better the oral health of the children in our community who would otherwise not have access to necessary care. Our volunteers give freely of their time and like to be productive when they are in the clinic. For that reason, if you are more than 15 minutes late for your scheduled appointment time, we reserve the right to give your appointment time to another child in need. We will do our best to reschedule your child's appointment in a timely manner based on availability.

I HAVE READ & UNDERSTAND THIS POLICY:

Parent/Legal Guardian's Signature: _____ Date: _____