PRASAD®
Children's Dental Health Program

Important **Please fill out this form if you want your child to receive our dental services at the school.**

CONSENT FORM PLEASE COMPLETE WITH INK SECTIONS 1 – 5 AND RETURN TO THE TEACHER

1. Your child's information

Child's Name _____ Birth date _____

Parent's Name _____

Address _____Zip Code:_____

Telephone _____ Email _____

Emergency phone:_____ School _____

Sex: F___M ___Grade____ Race:_____

2. Your child's dental insurance

- ❑ Medicaid ID#_____
- ❑ Other (WellCare, Fidelis, MVP, Delta)_____
- ❑ I do not have dental insurance, and would like to be contacted regarding the Sliding Fee.

Date of last dental visit:_____

3. Health History

If you don't know or are not sure of the answer to any of these, please call or visit the Mobile Dental Clinic as we cannot provide care without all of this information.

- Who is your child's medical doctor? _____ Phone: _____
- Is your child taking any medicine(s)? ____YES NO____
  If yes, what medicine and for what purpose? _____
- Has your child ever had any of the following? Please check appropriate box

Heart Murmur	Radiation Treatment	Sinus Trouble	Cancer or Tumors
Autistic	Asthma	Emotional Problems	Lung Disease
Epilepsy/Seizure	Prolonged Bleeding	Sickle Cell Anemia	HIV or AIDS
Hemophilia	Liver Disease (Hepatitis)	Pneumonia	Artificial Joint
Heart Disease	Measles	Jaundice	Hives
Convulsions	Chicken Pox	Rheumatic Fever	Physical Handicap
Blood Transfusion	Hay Fever	Fainting	Thyroid Problems
Diabetes	Arthritis	Ulcer or Colitis	Kidney Problems
Anemia	Bladder Problems	Mumps	Tuberculosis
Speech/Hearing Problems	Whooping Cough	Eye Problems	Cleft Lip/Palate
Tonsillitis			

- Are your child's immunizations up-to-date? ____YES NO____
- If no, please explain _____
- Has your child ever had an allergic reaction? ____YES NO____

If yes, please explain _____

I understand that in the event there is any change in my child's health status, I will notify your office at the earliest possible time.

Required

4. Parent/Guardian Signature X:_____Date _____

We will schedule your child during regular school hours. However, if you wish to be present at his/her appointment or if you have any questions, or a dental emergency please call (845) 866-4562 or our office at (845) 434-0376 x 216. Main office: 25 Sullivan Ave., Liberty, NY 12754. Mailing address: P.O. Box 576, Ferndale, NY12734.

PLEASE COMPLETELY FILL OUT THIS FORM AND RETURN IT TO THE SCHOOL!

CONTINUE →

CONSENT AND WAIVER

Child's Name _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate.

I give consent for my child to receive a dental treatment including x-rays. If my child requires any additional dental treatment, the dentist will provide these services which may include any or all of the following: fillings, extractions, crowns, and pulp therapy. I understand that I will be notified before any additional work is started. I also understand that it may not be possible to do all the needed treatment on the mobile dental clinic.

The side effects associated with treatment could be: accidental biting or scratching of the lip/cheek by the child if local anesthesia "is used and temporary discomfort, swelling or bleeding.

I expressly release PRASAD Children's Dental Health Program, Inc., its directors, officers, agents, representatives, licensees, successors, employees, and assignees from any and all claims (including right of publicity, right of privacy, performance rights and copyrights) which I have or may have arising out of production, reproduction, use, broadcast, exhibition, distribution, or promotion of any portion thereof.

I also consent to having my child's doctor release my child's medical record to PRASAD Children's Dental Health Program, Inc. if my child's health history shows health problems that may affect his/her dental treatment on the mobile dental clinic. In addition, I consent to having PRASAD Children's Dental Health Program release and receive any and/or all information related to my child's health status to and from the Department of Family Services and other social service or health care providers.

Recent HIPPA regulations focus on protecting patient confidentiality. One component of the regulations prohibits leaving messages on patient answering machines. I understand that in order to offer a best possible service, it is necessary to utilize answering machines. I authorize PRASAD Children's Dental Health Program and its representative to send text messages and leave information on my answering machine for services such as reminder for treatment and appointments. I understand that the consent shall remain in effect until I choose to end it, and that I am free to withdraw my consent at any time by written notification to PRASAD Children's Dental Health Program, Inc. I have read and understand this consent form, and have asked questions that I had, and all questions have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may come up during the course of my child's treatment, and that there are no guarantees regarding any treatment results. I understand that I will receive a l report on all treatment received at the clinic.

I hereby authorize the release of any medical /dental information to the Insurance Co., and third party billed, necessary to process my Ins. Claims. I assign the payment of dental benefits payable to: PRASAD Children's Dental Health Program, Inc. I will inform your office of any changes in my child's insurance coverage.

I represent that I am the legal guardian of the above named child and that I have the legal authority to make health care decisions on the child's behalf. If my child receives dental care, I waive any claims, which I may have against the program provider, namely, PRASAD Children's Dental Health Program, Inc., its agents, directors, officers, or employees as a result of the performance of said services.

If there are services uncovered by your insurance, you will receive in advance an estimate of the amount that you will be billed before services are rendered.

This consent and waiver shall be binding on my executors, administrators, heirs, legatees and assignees and shall be construed and enforced according to the laws of the State of New York, USA, exclusive of its choice of law rules.

Required **5. Parent or Guardian Signature X :**_____ **Date**_____

Relationship to Child _____