PRASAD®
holistic | sustainable | life-changing
Children's Dental Health Program

Please complete form if you want your child to receive our dental services at the school.

PLEASE COMPLETE ALL SECTIONS 1 – 5 AND RETURN TO THE SCHOOL

1. Your child's information

All Required

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#_____SS#_____
- Other insurance: _____
- I do not have dental insurance and would like to be contacted regarding the Sliding Fee.

Date of last dental visit: _____

*** Information Required by Medicaid and Dental Insurances for Billing Purposes**

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 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 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 receive a copy of the treatment plan if any additional work is needed. 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 rights of publicity, privacy, performance rights, and copyrights) which I have or may have arising out of the production, reproduction, use, broadcast, exhibition, distribution, or promotion of photographs, video or audio recordings, or other media materials in which I (or my child) may appear. This release applies in perpetuity and includes all forms of media now known or later developed, for any lawful purpose.

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.

HIPAA regulations focus on protecting patient confidentiality. One component of these regulations discourages leaving messages on patient voicemail without consent. I understand that in order to offer the best possible service, it is sometimes necessary to use voicemail. I authorize PRASAD Children's Dental Health Program and its representatives to send text messages and leave voicemail messages regarding services such as appointment reminders and treatment follow-ups.

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 _____