PATIENT INFORMATION and CONSENT FORM

**The information requested is very important. In order for your child to receive dental care provided by the Jordan Valley staff, you will need to read this form carefully and complete both sides for your child. Please make your answers as complete and accurate as possible. This will help us provide the best possible dental care for your child. This information form becomes part of our permanent record and will be held in strict confidence. If you are unable to complete this form by yourself, please ask for assistance. Please contact your school nurse or the Jordan Valley Dental Clinic at 417-831-0150 with any questions you may have. Thank you.

1.	Name of Patient Sex M / F
2.	Age Date of Birth// Weight Social Security#
3.	Grade School patient attends
4.	Is your Child a Bus rider? Pick up? and/or Walk home?
5.	Home address: Street
	City State Zip
6.	Telephone numbers: HomeCell Work
7.	Does the child have private dental insurance? YES NO
8.	Does the child have Medicaid/MO HealthNet? YES NO Medicaid Number
Reason(s	ne of Parent/Legal Representative: Date of Birth:/ Relationship to patient:) for seeking dental care for you child:
]	Routine check-up Toothache Other(specify)
	Has your child seen a dentist before? Yes No
	If yes, date of last visit and treatment received?
A	Any unpleasant experiences in a dental office?
CONSEN	NT AND AGREEMENT:
before an including private de certify the	policy to ensure that you are informed of the treatment that we plan to provide and to obtain your written informed consent y dental treatment is provided for you child. I have been informed there are some risks inherent in all dental procedures the administration of local anesthesia. I am aware that the risks are essentially the same as those procedures performed in a entist's office (for example, possible allergic reaction to anesthetic drug, possible accidental cuts or abrasions). Further, I at I understand and agree to the conditions set forth above. I also understand I am free to ask any questions regarding the early risk involved.
	give consent to the Jordan Valley Dental Clinic staff to perform on(child's name) those and treatments, including local anesthesia, which are deemed necessary with the exception of
This trea	tment consent will be in effect for the year August 1, 2012 to July 31, 2013.
Signature	Date



Please note the federal government requires us to ask you for this information and it will be used for government reporting purposes only. Your name nor any other identifying information will ever be disclosed and we will not use this information for any other purpose.

Please circle your family size and the range of your annual income.

Family Size	A	В	С	D		
1	\$0 - \$ 11,170	\$ 11,171 - \$ 16,755	\$ 16,756 - \$ 22,340	\$ 22,341 or greater		
2	\$0 - \$15,130	\$ 15,131 - \$ 22,695	\$ 22,696 - \$ 30,260	\$ 30,261 or greater		
3	\$0 - \$ 19,090	\$ 19,091 - \$ 28,635	\$ 28,636 - \$ 38,180	\$ 38,181 or greater		
4	\$0 - \$ 23,050	\$ 23,051 - \$ 34,575	\$ 34,576 - \$ 46,100	\$ 46,101 or greater		
5	\$0 - \$ 27,010	\$ 27,011 - \$ 40,515	\$ 40,516 - \$ 54,020	\$ 54,021 or greater		
6	\$0 - \$ 30,970	\$ 30,971 - \$ 46,455	\$ 46,456 - \$ 61,940	\$ 61,941 or greater		
7	\$0 - \$34,930	\$ 34,931 - \$ 52,395	\$ 52,396 - \$ 69,860	\$ 69,861 or greater		
8	\$0 - \$38,890	\$ 38,891 - \$ 58,335	\$ 58,336 - \$ 77,780	\$ 77,781 or greater		
9	\$0 - \$ 42,850	\$ 42,851 - \$ 64,275	\$ 64,276 - \$ 85,700	\$ 85,701 or greater		
10	\$0 - \$ 46,810	\$ 46,811 - \$ 70,215	\$ 70,216 - \$ 93,620	\$ 93,621 or greater		

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

■ Abdominal pain	//	☐ Cortisone/steroid	//	Malignant Hyperthermia	//
☐ ADD / ADHD	//	Medicine		Migraine headaches	//
☐ Allergies	//	Coronary artery disease	//	Mitral valve prolapse	//
☐ Anemia	//	☐ Crohn's disease	//	☐ MRSA infection	//
☐ Anxiety	//	Cystic Fibrosis	//	Osteoporosis	//
☐ Arthritis	//	Depression	//	☐ Pneumonia	//
Location:		Diabetes	//	☐ Pregnancy	//
☐ Artificial heart valve	//	☐ Dizziness/Fainting spells	//	☐ Psychiatric care	//
☐ Asthma	//	☐ Down's syndrome	//	☐ Radiation to head/neck	//
Rescue inhaler Yes/No		■ Emphysema	//	☐ Sinus trouble	//
☐ Atrial fibrillation	/ /	☐ Gallbladder disease		Spina bifida	/
☐ Autism/Asperger's		☐ Hearing problems		☐ STD's	/
☐ Blood clots		☐ Heart attack		Type:	
☐ Breastfeeding		☐ Heart murmur		☐ Stomach ulcer	/ /
		Pre- Med Y or N			
■ Bronchitis	//	☐ Heart trouble/disease	//	☐ Stroke	//
☐ Bruise easily/	//	☐ Heartburn	//	☐ Taken or taking	//
Excessive bleeding		Hemophilia	//	bone density	
☐ Cancer	//	Hepatitis	//	Medications	
Type:		Type:		Taken Phen-Fen	//
☐ Chemotherapy/	//	☐ Herpes	//	Or Redux	
Radiation Treatment	//	High blood pressure	//	Taking blood thinners	//
☐ Chest Pain	//	High Cholesterol	//	Thyroid disease	//
☐ Chicken pox	//	History of endocarditis	//	☐ Trauma to head/neck	//
☐ Cognitively	//	☐ HIV	//	Vision problems	//
Developmentally		Irregular heart beat	//	Other:	
Disabled		 Irritable bowel disease 	//		//
☐ Cold sores /	//	☐ Jaw pain	//		//
Fever blisters		☐ Kidney disease	//		//
□ Concussion	//	Learning disability	//		//
Convulsions / Enilensy	/ /	☐ Liver disease	/ /		/ /

					Nam	e/DOB			
Surgical History Please check all that apply.									
 □ Angioplasty □ Congenital heart Conditions □ Ear tubes □ Family History of problems with anesthesia □ Heart Stent 	 			□ H □ H □ H □ K □ C	Heart surgery Heart transplant Heart valve Problems Hip replacement Thee replacement Other joint replacen Tonsil/adenoid remo			// //	
					Pediatric	History			
Parents/siblings with cavities? Fluoride in water? Uses a sippy cup? Child is put to bed with a bottle or sippy cup? Fluoride toothpaste used? Uses a pacifier? Sucks thumb/finger? Times per day teeth are brushed						 Yes Yes Yes Yes Yes Yes Yes 	 □ No 		
					Social H	listory			
Do you use tobacco? Packs per day?		Yes		No	☐ Former Yea	Type of tobacco urs smoked?	/ Year Quit?		
Do you drink alcohol? How much per week?		Yes		No I	☐ Former Last Drink?	Year Quit?			
Have you ever used illegal drugs? Yes No Type									
Medication 1. 2. 3. 4. 5. 6. 7.				3		8. 9. 10. 11. 12. 13.	is s		
7.						14.			

4. 5. 6.

Allergies

☐ No known allergies

Allergy

Maternal illness / complications	Yes	No	Stayed in NICU		Yes		No		
Type:			Intubation in NICU		Yes		No		
Premature Birth	Yes	No	Feeding history	☐ Bot	Brea h	ıst		Bottle	
Birth weight	 lbs	 _oz							