University Pediatric Dentistry

UPD DENTAL ASSOCIATES

# Gateway to a Dental Home

Date:___/_____/_____ PS #: _____ Homeroom #: _____

**NOTE: WE WILL NOT BE ABLE TO SEE YOUR CHILD FOR DENTAL CARE IF THE BELOW INFORMATION IS NOT RECEIVED BEFORE HIS/HER APPOINTMENT.**

## PATIENT INFORMATION

| | | |
|---|---|---|
| Child's Last Name: | Child's First Name: | |
| Child's SSN #: | Sex: Male / Female | DOB: / / |
| Address: | City: | Zip Code: |
| Language: | Teacher's Name: | |

## PARENT OR GUARDIAN INFORMATION

| | | |
|---|---|---|
| Parent/Guardian's Name: | Sex: M / F | DOB: / / |
| Address: | City: | Zip Code: |
| SSN #: | Cell Phone: | |
| Home Phone: | Work Phone: | |

## TYPE OF DENTAL COVERAGE

Insurance Company: ☐ No Dental Coverage

Please Enter ID #: Medicaid # (if applicable):

## HEALTH INFORMATION

Include the name and telephone of your child's doctor:

| | | | |
|---|---|---|---|
| Is your child in good health? | | Yes | No |
| If no, explain: | | | |
| Is your child taking prescription and/or over-the-counter medication? | | Yes | No |
| If yes, list medications: | | | |
| Is this your child's first dental visit? | Yes | No | Not Sure |
| If no, has it been over 12 months since his/her last visit? | Yes | No | Not Sure |
| Does your child have any existing dental problems/concerns? | | Yes | No |
| If yes, explain: | | | |

Does your child (listed above) have any history of, or conditions related to, any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Epilepsy | ☐ HIV +/AIDS | ☐ Sickle Cell Anemia |
| ☐ Asthma | ☐ Emotional Disorders | ☐ Intellectual/Dev. Disability | ☐ Speech Impairment |
| ☐ Autism | ☐ Excessive Bleeding | ☐ Kidney Disease | ☐ Thyroid Disorder |
| ☐ ADD | ☐ Hearing Loss | ☐ Liver Disease | ☐ Tuberculosis |
| ☐ ADHD | ☐ Heart Disease | ☐ Low Blood Pressure | ☐ Tumors |
| ☐ Anxiety | ☐ Heart Murmur | ☐ Lung Disease | ☐ Venereal Disease |
| ☐ Cancer | ☐ Hemophilia | ☐ Pregnancy | ☐ Other |
| ☐ Diabetes | ☐ Hepatitis | ☐ Rheumatic Fever | |
| ☐ Earaches | ☐ High Blood Pressure | ☐ Seizures | |

**Please list any known allergies:**

☐ **Does your child require antibiotics prior to having a dental procedure? If yes, please list all and include reason:**

## DENTAL CARE CONSENT FORM - **PLEASE CHECK ONLY ONE BOX AND SIGN AT THE BOTTOM**

1) ☐ **Yes, I grant consent for my child to receive treatment (if deemed necessary), as described below, at either 1100 Main Street, Buffalo, NY or 515 Abbott Road, Buffalo, NY, including round-trip bus transportation from his/her school.**

**OR**

2) ☐ **Yes, I would like my child to have a dental screening provided at no cost. I do not want him/her to receive treatment.**

- I consent to my son/daughter receiving a dental examination, cleaning, fluoride treatment, filling(s), sealant(s), stainless steel crown(s), baby tooth root canal(s), x-rays, and brushing/flossing instructions.
- I consent to my son/daughter receiving nitrous oxide (laughing gas) to help relieve any anxiety he/she may experience.
- I consent to my son/daughter receiving local anesthesia (numbing medicine).
- I understand the risks associated with treatment include, but are not limited to, accidental biting or scratching of lip/cheek by the child (if local anesthesia is used) and/or slight discomfort, bleeding and/or swelling.
- I consent to University Pediatric Dentistry contacting my son/daughter's medical doctor and for him/her to release any medical information needed for my child's treatment.
- I consent to University Pediatric Dentistry contacting my child's school nurse and/or Health Related Services/ Buffalo Board of Education to obtain current information regarding my son/daughter's current health.
- Photographs may be taken for educational purposes. If no, please check here: ☐

✓ I will be notified of any treatment my son/daughter may need that is not available through the Gateway to a Dental Program.

✓ University Pediatric Dentistry respects your child's privacy. All information will be kept confidential.

***Your child's general physical health can be affected by untreated dental problems, which may lead to pain, swelling and/or serious infection.***

I hereby grant permission to University Pediatric Dentistry to bill my child's insurance company. I will accept financial responsibility for the care provided to my child.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name **(Please Print)**

## *If you do not want your son/daughter to participate, please check below:*

3) ☐ **No, I do not want my son/daughter screened and I do not want him/her enrolled in the Gateway to a Dental Home Program.**