APPLE TREE DENTAL

Head Start / Outreach
Oral Health Plan & Consent Form

2001 W. Lincoln Ave. Suite 33
Fergus Falls, MN 56537
Phone: 218-998-2218
Fax: 218-998-2213

Patient's Full Name: ______________________ Last First M.I. Preferred Name: ____________

Site Location: ______________________ Classroom: ____________

☐ Male ☐ Female Birth Date: ____________ Soc. Sec.#: ____________

Address: ______________________ City: ____________

State: ______ Zip Code: ______ County: ____________ Phone (H): ____________

Race: (check one) ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Preferred Language: (if other than English) ____________

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Please Check One of the Following Oral Health Plans:

☐ 1) I choose Apple Tree Dental to be the dental provider for my child.

Purpose of Consent: By signing this form, I authorize Apple Tree Dental to provide comprehensive and periodic oral evaluations, x-rays and preventive care. If these services are denied by my insurance carrier, I will be held responsible for payment, up to $250.00 for these services. Following each evaluation, I understand that I will be provided with a written treatment plan and treatment will not be started without further consent. I authorize the release of x-rays and or dental records from my previous dentist. I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care coordination.
Right to Revoke: I have the right to revoke this Consent at any time by giving written notice of my revocation submitted to Apple Tree Dental. I understand that revocation of this Consent will not affect any action Apple Tree Dental took in reliance on this Consent before they received my revocation and that they may decline to treat me or to continue treating me if I revoke this Consent.

☐ **I have received a copy of Apple Tree Dental's Notice of HIPAA & Privacy Practices**(check the box)

Dental Clinic Appointment Policy

If for any reason you are unable to keep an appointment, please notify our office 24 hours in advance. Missing an appointment without such notification will be considered a failed appointment. Failure to keep two dental appointments will result in you being placed on restrictive scheduling and will allow you to only make same day appointments. Please be on time for your appointment. If you are not able to be on time, your appointment may be given to another patient who is waiting.

☐ **I have read Apple Tree Dental's Appointment Policy** (check the box).

***Parent/Guardian must SIGN BELOW:**

Signature: ______________________ Date: ____________

Name: ______________________ Phone (H): ____________

Address: ______________________ Phone (C): ____________

City: ____________ State: ______ Zip: ______ Phone (W): ____________

E-mail: ______________________ Relationship to Patient: ____________

Preferred contact method (check one): ☐ Home Phone ☐ Wireless Phone ☐ Work Phone ☐ E-mail

Previous Dentist: ______________________ DDS Phone #: ____________

Date of Last Dental Exam (Check-up): ____________

☐ 2) I already have a dental provider for my child.

I will make arrangements with Dr.____________ to provide oral health care and will also provide Head Start/Outreach with a written record of a dental exam completed within the first 90 days of the school year.

Date of last exam: ____________

Please complete Page 2

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Patient Name: ______________________ Site Location: ______________________

Financial Information

Check boxes applicable and complete information below

☐ Private Pay, Financial Guarantor

If someone other than the patient/representative indicated on page 1 is responsible for payment, please complete below.

Name: ______________________ Phone (H): ______________

Address: ______________________ Phone (C): ______________

City, State, Zip: ______________________ Phone (W): ______________

E-mail: ______________________ Relationship: ______________

Preferred contact method (check one): ☐ Home Phone ☐ Wireless Phone ☐ Work Phone ☐ E-mail

☐ Medical Assistance or MNCare

ID#: ______________________

☐ Dental Insurance Information **Present your dental insurance card to our staff.**

Insurance is designed to reimburse the policyholder for loss and is a contract between the policyholder and the insurance company. As a courtesy to you, we will submit your insurance claims on your behalf and will do all we can to help you collect legitimate claims. In the event your company is slow to pay or disallows the claim payment, the amount owed is your responsibility.

Policy Holder Name: ______________________ Relationship to Patient: ______________
First M.I. Last

Policy Holder SS #: ______________________ Policy Holder Birthdate: ______________

Insurance Company: ______________________ Insurance phone: ______________

Group #: ______________ Insurance ID#: ______________________

Insurance Co. Billing Address: ____
Address: City State ZIP

DO YOU HAVE DUAL INSURANCE COVERAGE? ☐ No ☐ Yes If yes, please complete the following

Policy Holder Name: ______________________ Relationship to Patient: ______________
First M.I. Last

Policy Holder SS #: ______________________ Policy Holder Birthdate: ______________

Insurance Company: ______________________ Insurance phone: ______________

Group #: ______________ Insurance ID#: ______________________

Insurance Co. Billing Address: ____
Address: City State ZIP

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APPLE TREE DENTAL

Pediatric Health History Form

Patient's Name: ______________________ **D.O.B.** __________

If you are filling out this form for another person, please fill out the following:

Your Name: __________
Relationship to the Patient: __________
Phone #: (h) __________ (w) __________

Dental History

1. Former Dentist: __________ Address: __________
2. When did your child last visit a dentist? __________
   X-rays taken? ☐ Yes ☐ No If yes: ☐ Full Mouth Series ☐ Bitewing (molar only) ☐ Panoramic
   What was done at that time? __________
   Why did you leave that dentist? __________
   Has any dental treatment been recommended to your child that they have not done? __________
3. Does your child have a toothache or other immediate dental problems? __________
4. Has your child ever had a toothache? __________
5. Has your child had any injury to the mouth, teeth or jaws (fall, blow, etc.)? __________
6. Has your child ever had an unfavorable dental experience? __________
7. Is (was) your child nourished by nursing beyond one year of age? Yes ☐ No ☐
   If yes, check: Breast ______ Nursing bottle ______ Both ______, and to what age? __________
8. Does your child fail to eat a well-balanced diet? __________
   If yes, what foods or food groups are not adequate? __________
9. Does (or has) your child have (or had) sucking habit beyond one year of age? __________
   If yes, check Thumb(s) ______ Finger(s) ______ Pacifier ______ Other: __________
10. Does (or has) your child have (or had) any other oral habits beyond one year of age? __________
    If yes, check: Lip biting ______ Mouth breathing ______ Nail biting ______ Teeth grinding ______ Other ______

Dental Disease prevention

1. How often does your child brush? ______ time(s) per ______
2. Does your child use dental floss? __________
3. Does someone assist your child with brushing and cleaning the teeth? __________
4. Does someone inspect for throughness after brushing? __________
5. Does your child use a fluoride toothpaste? __________
6. Has your child ever had a fluoride treatment? __________
7. Has your child ever taken a fluoride supplement or vitamins with fluorides? __________
8. Drinking water source: City water supply ______ Name of City: __________
   Private well or other than city? ______ Has a fluoride analysis been done? __________
   Date of analysis __________ Fluoride content __________

Medical History

1. Physician: __________ Phone #: __________ Address: __________
2. When was your child's last medical examination? __________
3. Is your child under the care of a physician? If yes, for what reason(s)?
   ____
4. Is your child presently taking any medications/drugs (include over-the-counter meds)?
   If yes, please list medications.
   ____
5. Is your child allergic/sensitive to: ☐ Penicillin ☐ Amoxicillin ☐ Codeine ☐ Local anesthetic ☐ Latex ☐ None
   Other Allergies: __________
6. Does your child smoke or use tobacco? ______ If yes, how many packs per day? ______ How long? ______

Please complete the backside of this form

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APPLE TREE DENTAL

Pediatric Health History Form

9. Does your child have, or ever had:

Condition		
Congestive heart failure	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Mitral valve prolapse with regurgitation	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
Heart pacemaker	☐ Yes	☐ No
Heart valve replacement	☐ Yes	☐ No
Hypertrophic cardiomyopathy	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Rheumatic heart disease	☐ Yes	☐ No
Congential heart defects	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy/Seizure disorder	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Thyroid problem	☐ Yes	☐ No
Excessive or prolonged bleeding	☐ Yes	☐ No
Fainting spells	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Hepatitis (Type _____)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Tube Feeding	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotheraphy/radiation	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Lung disease	☐ Yes	☐ No
Hearing impaired	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Artificial Joint (knee, hip, etc.)	☐ Yes	☐ No
Date of surgery: ________		
Oral herpetic lesions (cold sores)	☐ Yes	☐ No
HIV positive/AIDS	☐ Yes	☐ No
Physical Therapy	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No

10. Have you had any other serious illness, hospitalization or accident? ☐ Yes ☐ No
If yes, please explain: ____________________

11. Any Learning, behavioral, excessive nervousness, or communication problems?
____

12. Why did you choose Apple Tree? ____________________

Parent/Guardian Signature* : ____________________ **Date:** __________

Emergency Contact: ____________________ Phone #: __________

Update date: __________
Parent/Guardian Signature __________
Dentist Signature __________

Update date: __________
Parent/Guardian Signature __________
Dentist Signature __________

Update date: __________
Parent/Guardian Signature __________
Dentist Signature __________

Update date: __________
Parent/Guardian Signature __________
Dentist Signature __________

Update date: __________
Parent/Guardian Signature __________
Dentist Signature __________

Update date: __________
Parent/Guardian Signature __________
Dentist Signature __________

Apple Tree Use Only

Medical Consults

Yes		Yes	
☐	Antibiotics **-ABX**	☐	Coumadin **-COU**
☐	Sedation **-SED**	☐	Other **-OTH** ________

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