TeamSmile®
Dental and Sports Professionals Teaming Up To Provide Free Dental Healthcare

Patient Consent for Dental Treatment and Health History

Please complete this form, front and back, and sign as parent or guardian for your child on front and back ("patient").
TeamSmile will provide free dental care and preventative care including, but not limited to, diagnostic exams, x-rays, cleanings, sealants, fillings, extractions, pulpotomies, crowns, and silver diamine fluoride (SDF) while educating the patient on the value of a life-long commitment to oral health care.

Information About the Patient to Be Completed by Parent or Guardian

School or Organization Patient is With: _____
Patient's Name (one patient per form):_____
Age: _____ Patient's Date of Birth: _____Patient's Gender: Male _____ Female_____
Home Address: _____
City: _____ State: _____ Zip: _____
Medicaid Eligible (*for follow-up dental care*): Yes_____ No_____
Race/Ethnicity (circle all that apply) American Indian/Alaska Native Asian Black/African American Native Hawaiian/other Pacific Islander Hispanic/Latino White Other_____
Language(s) spoken in home: _____

Name of Parent/Guardian: _____ Relationship to Patient: _____
Email: _____ Cell/Mobile Phone: _____

IN CASE OF EMERGENCY CONTACT on the day of service:
First Name: _____ Last Name: _____
Preferred Phone: _____ Alternative Phone: _____

For each question, indicate consent (yes) or no consent (no) by placing an "x" in the appropriate boxes below.

Yes	No	
		Preventive and Diagnostic Services: teeth cleaning, oral hygiene instructions, fluoride treatment and screening.
		Emergency Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthesia may be used for these procedures. X-rays will be taken.
		Emergency Extraction of Primary (Baby) Teeth: Removal of primary teeth that cannot be restored through other treatments. Local anesthesia may be used for this procedure. X-rays will be taken.
		Emergency Extraction of Permanent Teeth: Removal of permanent teeth that cannot be restored through other treatments. Local anesthesia may be used for this procedure. X-rays will be taken.
		Silver Diamine Fluoride (SDF) a liquid that helps stop tooth decay. SDF is applied every 3, 6 or 12 months. A small amount will be applied to the decayed tooth area – no eating or drinking for 60 minutes after application and do not brush the tooth until the following morning. The decayed area will stain black permanently. X-rays will be taken. **Healthy tooth structure will not stain**. Child should not be treated with SDF if 1) they are allergic to silver. 2) There are painful sores or raw areas on their gums or anywhere in their mouth

Benefits of receiving SDF: Helps stop tooth decay. Fast. Do not need to numb teeth. Does not hurt.

Risks of receiving SDF: The affected area will stain black permanently (See Photo). This means SDF is working. Tooth-colored fillings and crowns may discolor if SDF is applied to them. After SDF treatment, a filling or crown might still be needed. Allergic reaction. Risk that the procedure will not stop the decay. Not every cavity can be treated with SDF.

I understand the patient will not receive dental treatment unless my consent is given. I further understand that no promise, guarantee or warranty has been made regarding the results of any treatment or procedure. I understand that there are inherent risks in any dental treatment, including but not limited to swelling, bruising, allergic reaction, changes in pain, etc. By signing below, I agree to NOT hold TeamSmile or its volunteers liable for performing any preventative care or dental treatment diagnosed and recommended by licensed dental professionals. TeamSmile's mission is to provide your patient free dental and preventative care. You may revoke this consent at any time, except to the extent it has been relied upon, by emailing a written request to: info@teamsmile.org. I attest that I understand the information on this form and that I have been given the opportunity to ask any questions that I may have.

Name of Parent/Guardian (Printed) _____

Signature _____ Date _____

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Health History
Form Must be Completed for Treatment

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that the patient may have, or medication that **the patient may be taking or has taken**, could have an important interrelationship with the dentistry the patient will receive. Thank you for answering the following questions.

Is the patient under a physician's care now?	□ Yes □ No	If yes, explain: _____
Is the patient taking any medications?	□ Yes □ No	If yes, explain: _____
Has the patient been hospitalized due to a dental emergency?	□ Yes □ No	If yes, explain: _____
Has the patient ever seen a dentist before?	□ Yes □ No	
Does the patient presently have a dentist?	□ Yes □ No	If no, would you like assistance in finding one? □ Yes □ No
Is the patient having any dental pain now?	□ Yes □ No	

Is there anything else we should know about the health of the patient? List: _____

Has the patient had a history of or had difficulty with the following? Check any that apply

□ ADD/ADHD	□ Cerebral Palsy	□ Eating Disorders	□ High Blood Pressure	□ Sinus Problems
□ AIDS/HIV	□ Chronic ear infections	□ Epilepsy/seizures	□ Kidney Disease	□ Stomach/Intestinal Disorders
□ Anemia	□ Cold sores/Herpes	□ Excessive Bleeding	□ Liver Disease	□ Tuberculosis
□ Asthma	□ Convulsions	□ Fainting	□ Migraines	
□ Autism	□ Diabetes Type I	□ Hearing Problems	□ Mono	
□ Cancer	□ Diabetes Type II	□ Heart Problems	□ Respiratory Problems	

Has the patient ever had any serious illness not listed above? □ Yes □ No If yes, please explain: _____

Is the patient allergic to any of the following? □ No allergies

□ Aspirin □ Penicillin □ Codeine □ Metal □ Silver □ Latex □ Local Anesthetic □ Other _____

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform TeamSmile of any changes to the patient's medical status.

Signature of Parent/Guardian_____ Date _____

Authorization for Release of Protected Health Information

By signing this document, you are allowing TeamSmile staff to give or receive your child's health care records to other healthcare providers, or child agencies to provide the best care for your child. The records may be sent to another dentist, dental specialist or other healthcare entity that TeamSmile staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

I hereby authorize: TeamSmile: 2021 Burlington Street, Kansas City, MO 64116; Phone: (816) 820-0640 to receive from or release to the appropriate healthcare provider or agency, my child's records to facilitate their healthcare needs and/or treatments.

Signature of Parent/Guardian_____ Date_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____

Photographic/Media Release

I voluntarily and knowingly authorize TeamSmile to take Photographs of my child for publicity purposes on behalf of TeamSmile. "Photographs" may include video or still photography, as well as related prints, negatives, computer graphics, or electronic images.

I understand that I can request that Photographs of my child not be taken or used at any time; however, such a request will not have any effect on Photographs that have already been taken of my child and permissibly used.

I hereby give TeamSmile the absolute right and permission to publish or otherwise use or disseminate, including to media outlets and TeamSmile supporting organizations, in part or in whole, my child's name, story, and any Photographs taken of them pursuant to this Release, for marketing and public relations purposes, including but not limited to: Website, Brochures/Flyers, Newsletters, and Social Media, such as Facebook.

I acknowledge that any Photographs that are taken of my child pursuant to this Release will be the sole property of TeamSmile. I understand that I will not have the right to receive a copy, inspect, or approve any Photographs prior to the uses authorized above. I understand that consenting to permit the use of my child's name, story and Photographs is of no direct benefit to me or my child. I waive any and all rights that I may have to any claims for payment or royalties in connection with the use and disclosure of such information and Photographs. I, along with my heirs, representatives, and beneficiaries, will hold TeamSmile harmless from and against any claim for injury or compensation resulting from the use of my child's information and Photographs in accordance with this Release.

I acknowledge that TeamSmile may disclose my child's information and/or Photographs to a media outlet or any supporting organization of TeamSmile pursuant to the foregoing authorization and that TeamSmile has no control over how such media outlet or supporting organization uses or presents my child's information or Photographs. As such, I hereby release and agree to hold TeamSmile harmless from any and all liability arising from a media outlet's use of my child's information or Photographs.

Signature of Parent/Guardian_____