Patient Application – Give Harnett Kids A Smile 2013

Fax – Fax all completed forms to HHPD/Harnett Smiles at **1-888-343-9351**
Scan / Email – Scan and email the forms to: **HarnettSmiles@gmail.com**
Mail – Mail completed forms to: **High House Pediatric Dentistry / Harnett Smiles**
351 Wellesley Trade Lane #212
Cary, NC 27519

Office use only:
MR#_____
Appt:_____
Ch#_____

Child's Full Name : _____
Date of Birth _____ Gender _____
Race/Ethnicity_____
Address _____City_____State__NC____Zip_____
Parent/Guardian Name: _____
Daytime Phone:_____ Evening Phone:_____ Email:_____
Do you prefer an appointment in the: **morning (9a-12p)** **afternoon(12p-3p)**
We will try to honor requests if our schedule allows for it

Please initial next to the following statements to certify that they are true to the best of your knowledge:

_____ I certify that the Parent and Child listed above both live in Harnett County, North Carolina.

_____ I certify that the Child listed above is not covered by ANY FORM of dental insurance, including Medicaid and NC Healthchoice.

_____ I give consent for my child to participate in the "Give Harnett Kids A Smile!" program, which will provide the following dental treatment as needed: Dental exam, fluoride treatments, dental cleaning, sealants (protective covering over teeth), basic health screenings, and educational materials on oral hygiene and nutrition.

Please answer the following questions:

1. Will you be enrolling any siblings of this child in the "Give Harnett Kids A Smile" Program? **NO** **YES** (list below):
   _____
2. Has this child ever seen a dentist? **NO** **YES**
   If yes, when was the last time? (Please circle): **1-6 months** **7-12 months** **More than a year ago**
3. Is this child in immediate need of dental services (i.e. broken tooth, infection, pain, etc.)? **NO** **YES**
4. Does the child have transportation available to and from dental appointments? **NO** **YES**
5. If dental care could be arranged for the child, what cities would the child be able to travel to for appointments (circle all that apply): **SANFORD** **FAYETTEVILLE** (Cumberland Cty) **CARY** (Wake Cty) **CHAPEL HILL** (Orange Cty) **RALEIGH** (Wake Cty)
6. Could you bring your child to more than one appointment? **NO** **YES**

HOW DID YOU HEAR ABOUT US? (Please identify the friend, school, church, organization):_____

_____

CHILD LIVES WITH : ___ Check here if same as above

First _____ MI _____ LAST_____

Address _____

Home Phone:_____ Cell Phone: _____

EMERGENCY CONTACT – TO BE USED IN CASE OF EMERGENCY ON DAY OF SERVICE AT THE EVENT:

First _____ MI _____ LAST_____

Address _____

Home Phone:_____ Cell Phone: _____

Medical History and Consent Form

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Office use only:
MR#_____
Appt:_____
Ch#_____

Child First Name:_____ MI_____ Last Name:_____

Date of Birth: _____ Gender: _____

Does your child have, or has your child had any of the following conditions:

Asthma	**Y**	**N**	Congenital Heart Disease	**Y**	**N**
Heart Murmur	**Y**	**N**	Rheumatic Heart Disease	**Y**	**N**
Diabetes	**Y**	**N**	Bleeding Problems	**Y**	**N**
Seizures	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**
Latex Allergy	**Y**	**N**			

When was the last time your child had a well-child checkup?_____
Is your child up to date on all vaccinations? **No** **YES**
Is your child taking any medications? **No** **YES (list):_____**
Does your child have any allergies? **No** **YES (list):_____**
Are there any other health problems we should be aware of? _____
_____
_____

I recognize that the doctors/dentist/staff that will treat/examine my child during the "Give Harnett Kids A Smile!" Day is at my request. I realize that my child's relationship with the dentist is limited to my child's visit today. I understand this is not my child's regular dental provider, and that my child is not his/her patient. I acknowledge that the dentist owes my child no duty to treat any dental condition my child may have. I understand that, if the dentist recommends need for further treatment for my child, it is my responsibility to make/keep that appointment and be sure that my child receives further care.

I give consent for my child to participate in the "Give Harnett Kids A Smile!" program, which may provide the following dental treatment as needed: dental exam, fluoride treatments, dental cleaning, sealants (protective covering over teeth), as well as other health screening and patient education services as previously outlined.

Name of Parent/Guardian (Please print) _____

Signature _____ Date _____

(Initial) _____ YES -I give permission for doctors/dentist/staff and any associated agents to photograph my child, and I consent to the reproduction of my child's image and voice by means of motion picture film process, magnetic video recordings process and/or still photography. I understand that I will not be compensated financially or otherwise for the use of the likeness of my child.