



Parental Consent, Registration & Health History Form

Child's Information (only one child per form)

First Name: _____ Last Name: _____

Date of Birth (mm/dd/yy) _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Child's Health History:	Circle all that apply:
<p>■ Does your child have a regular doctor? YES NO</p> <p>■ Has your child been seen in the last 6 months? YES NO If no, why? _____</p> <p>■ Has your child had an overnight stay in a hospital in the last 6 months? YES NO If yes, why? _____</p> <p>■ Does your child have any allergies? YES NO If yes, what? _____</p> <p>■ Does your child take medications? YES NO If yes, what? _____</p> <p>■ Is there anything else we should know about your child? _____</p>	<p>Asthma YES NO</p> <p>Heart Murmur YES NO</p> <p>Diabetes YES NO</p> <p>Seizures YES NO</p> <p>Heart Disease YES NO</p> <p>Blood Disorders YES NO</p> <p>Please explain: _____ _____ _____</p>
<p>■ Has your child been seen by a dentist before? YES NO</p> <p>■ Is your child covered by a insurance plan? <input type="checkbox"/> NJ Family Care <input type="checkbox"/> Pay for Service <input type="checkbox"/> None</p> <p>■ HMO: _____</p> <p>■ Insurance Number: _____</p> <p>■ Have you been to a Give Kids A Smile screening in the past? YES NO</p>	<p>I understand that my child may be photographed during this event and I understand that the photos may be used by Give Kids A Smile NJ, the ADA Foundation, or the American Dental Association in future educational and promotional material. All photographs, prints, and reproductions shall be the property of Give Kids A Smile NJ and no compensation will be provided for use of such reproductions. YES NO</p>

PARENT/GUARDIAN SIGNATURE

I certify that I have read and understood the above questions. The information that I have provided is correct to the best of my knowledge. I will not hold the New Jersey Dental Association or any other participating sites of the *Give Kids A Smile!* program or any member of the staff responsible for any errors or omissions I have made in the completion of this form. I also authorize the doctors, dental staff and dental students to perform the necessary dental services that my child may need including, but not limited to, cleanings, fluoride, sealants, x-rays, anesthesia, pulpotomies, extractions, and fillings.

Name of Parent/Guardian: _____

Signature: _____ Date: _____