School Based Health Center Collaborative

Abbottsford Fall Dental
4700 Wissahickon Avenue
Suite 110-B
Philadelphia, Pa 19144
(267)597-3600 x3

Sheller Drexel 11th St. Dental
850 N. 11th St.
Philadelphia, Pa. 19123
(215)769-1594

Health Annex Dental
6120 B. Woodland Avenue
Philadelphia, Pa 19142
(215)727-4721 x3

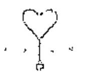
Consent to Dental Diagnostic Care

By signing this form I give my consent to The Family Practice & Counseling Network (FPCN) to administer appropriate radiographs (X-rays), dental sealants(a filling used to prevent cavities) and other diagnostic procedures, as may be necessary for any proper dental care examination, consultation or counseling. Further, I authorize FPCN to obtain Medication History related to my child from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment.

Name of Legal Parent/Guardian: ____ **Date:** ___________

Signature of Parent/Guardian:___________________________________ **Emergency Contact#:** _______________

Student(s) Name	Grade



CHILDREN'S HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Child's Name (Last, First, M.I.):	☐ M ☐ F	DOB:
Address		
City State: Zip	Social Security #	
Child's Medical Doctor:		Date of last physical exam:

Check Yes or No after each question:	YES	NO	Check Yes or No after each question:	YES	NO
Has your child ever been to a dentist before?			Does your child have any type of handicapping condition? If yes what?		
Were there any problems associated with any previous dental visits? If yes what?			Does your Child have any known drug allergies? If yes what?		
Is your child presently in good health?			Does your child have allergies to latex?		
Has your child ever experienced any unfavorable reactions to medicine or drugs? If yes what?			Does your child have any food allergies? i.e. nuts, seafood, etc. If yes what?		
Has your child ever had an operation? If yes why?			Has your child ever had bleeding gums?		
Is your child presently taking any medications?			Is your drinking water fluoridated?		
Is your child under a physicians care? If yes why?			Does your child take daily dietary fluorides? Tablets or Drops?		

Has your child had a history of:

	YES	NO		YES	NO
Heart trouble (heart murmur)			Chicken Pox		
High Blood Pressure			Measles		
Low Blood Pressure			Mumps		
Rheumatic Fever			Tonsillitis		
Bleeding Disorders			Seizures		
Diabetes			Cerebral Palsy		
Kidney or Liver Disease			Mental Retardation		
Tuberculosis			Asthma		
Allergies			Nervous Problems		
Polio			Speech Problems		
Anemia			Thumb/Finger sucking		
Tumors			Mouth breathing		
Scarlet Fever			Grinding teeth		
Young Women					
Does your daughter menstruate?					
Does your daughter take birth control pills?					
Does your daughter think she may be pregnant?					

List any other medical problems or information which you think we should know, such as a disease or conditions:

PARENT OR LEGAL GUARDIAN INFORMATION

Name (Last, First, M.I.):	DOB:
Address	
City State: Zip	Social Security #:
Phone:	Email:
Relation to Child:	

Consent for Treatment

I/we, the undersigned being legally responsible for______________________________, knowing that he/she is suffering from a condition requiring dental care, do hereby consent to such routine dental care as may be considered necessary or advisable for the patient by a member of the staff of the FPCN Dental Network. The undersigned hereby acknowledge(s) that no guarantees have been made to me/us concerning the results of any acts, procedures, diagnoses, or treatments. This form has been fully explained to me and I certify that I understand its contents.

Parent/Guardian Sign____________________________ Reviewed by ____________________________

Print Name: ____________________________ Print Name: ____________________________