SUPER SMILES FOR SUPERHEROES℠

CLEANING
FLOURIDE
SEALANTS
BRACES
TREATMENT
CROWNS
BLEACHING & MORE!

ESTABLISHED 1998

CHILD FRIENDLY

OPEN ALL YEAR

PARENTS WELCOME TO BE PRESENT

EMERGENCY CARE

AGES 1 AND UP

RETURN FORM TO SCHOOL NURSE OR MAIL TO:
A Plus Dental
PO Box 734
Litchfield Park, AZ 85340

© A Plus Dental

Se habla Español

A Plus Dental

YOUR SUPERHERO'S DENTIST℠

Parent Permission

Child's Last Name	First Name	Initial
Nickname	Date of Birth	Sex: M ☐ F ☐
School	Teacher	Grade
Parent's/Guardian's Name	Relationship to Patient	
PO or Mailing Address	City	Zip
Cell Phone	Other Phone	
Name of AHCCCS Plan	AHCCCS Number	
E-mail	Best way to contact you ☐ Cell Phone ☐ E-mail ☐ Text	

I am the parent or legal guardian of the child noted above. I want my child to participate, **if eligible**, in the free school dental program. I give my consent for my child to have their teeth cleaned, receive a dental exam, x-rays, sealants (protective coating), and clinical photographs, if needed, for insurance or educational purposes. I give the school district permission to transport my child and to provide and update any information requested on this form. A Plus Dental has permission to communicate the status of my child's dental care to the school district. I have received a copy of this office's Notice of Privacy Practices. This authorization will remain in effect until cancelled in writing by me.

SIGN HERE

Parent's/Guardian's Signature	Date
X	

Health History

Please (x) if your child has or had any of the following diseases or problems.

Yes	No	Dental Information
☐	☐	Toothache
☐	☐	Immediate Dental Problem
☐	☐	Injury to mouth, teeth, jaws
☐	☐	Unfavorable dental experience
☐	☐	Does child brush twice a day

Yes	No	Allergies
☐	☐	Local anesthetics
☐	☐	Aspirin
☐	☐	Penicillin or Amoxicillin
☐	☐	Other antibiotics
☐	☐	Barbiturates, sedatives
☐	☐	Sleeping pills
☐	☐	Sulfa drugs
☐	☐	Codeine or other narcotics
☐	☐	Latex
☐	☐	Iodine
☐	☐	Hay fever/seasonal
☐	☐	Other (Specify) ________________ ________________________

Yes	No	Medical Information
☐	☐	In good health
☐	☐	Under a physician's care
☐	☐	Taking any medications (If yes specify below)______________ ________________________ ________________________
☐	☐	Cardiovascular disease
☐	☐	Heart Murmur
☐	☐	Rheumatic heart disease

Yes	No	Medical Information
☐	☐	Artificial heart valves
☐	☐	Inborn heart defects
☐	☐	High blood pressure
☐	☐	Mitral valve prolapse
☐	☐	Abnormal bleeding
☐	☐	AIDS or HIV Infection
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Cancer/chemotherapy/radiation
☐	☐	Chronic pain
☐	☐	Diabetes Type I Insulin dependent
☐	☐	Diabetes Type II
☐	☐	Eating disorder
☐	☐	Epilepsy
☐	☐	Fainting spells or seizures
☐	☐	Hepatitis, jaundice or liver disease
☐	☐	Kidney problems
☐	☐	Mental health disorders (if yes specify) ________________________
☐	☐	Neurological disorders (if yes specify) ________________________
☐	☐	Persistent swollen glands in neck
☐	☐	Respiratory problems
☐	☐	Emphysema
☐	☐	Bronchitis
☐	☐	Sexually transmitted disease
☐	☐	Sinus trouble
☐	☐	Sores or ulcers in the mouth
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Are you pregnant? (Women only)
☐	☐	Other (Specify)________________

Please list other children in your family below

Last Name	First Name	Age