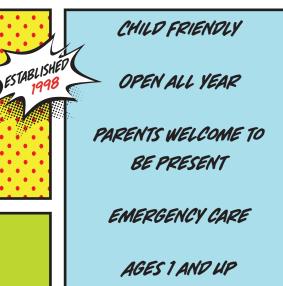




CLEANING FLOURIDE SEALANTS BRACES TREATMENT CROWNS BLEACHING & MORE!





RETURN FORM TO SCHOOL NURSE OR MAIL TO:

A Plus Dental PO Box 734 Litchfield Park, AZ 85340

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Se habla Español

A Plus Dental

YOUR SUPERHERO'S DENTIST

PAREN	- D-	DAMEC	
PAREN	II PE	KMI2,	

Child's Last Name	First Name	Initial	
Nickname	Date of Birth	Sex:	
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.

Parent's/Guardian's Signature

HEALTH HISTORY

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

Yes	No	DENTAL INFORMATION	Yes	No	MEDICAL INFORMATION
		Toothache Immediate Dental Problem Injury to mouth, teeth, jaws Unfavorable dental experience Does child brush twice a day			Artificial heart valves Inborn heart defects High blood pressure Mitral valve prolapse Abnormal bleeding
Yes	No	ALLERGIES			AIDS or HIV Infection Anemia
00000000000	00000000000	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)			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)
Yes	No	MEDICAL INFORMATION			Persistent swollen glands in neck Respiratory problems
		In good health Under a physician's care Taking any medications (If yes specify below) Cardiovascular disease Heart Murmur Rheumatic heart disease			Emphysema Bronchitis Sexually transmitted disease Sinus trouble Sores or ulcers in the mouth Thyroid problems Tuberculosis Are you pregnant? (Women only)
		Micamade fiedre disease			Other (Specify)

PLEASE LIST OTHER CHILDREN IN YOUR FAMILY BELOW

ast Name	First Name	Age