

**North Iowa Community Action Organization
DENTAL CONSENT FORM**

Child's name	Age	Date of Birth
Address:	Phone:	
Child's physician:	Child's dentist:	
Medicaid ID number:		

Please check all that apply:
 _____ **YES**, I give permission for my child to receive a dental screening and fluoride varnish application. (In order for fluoride to be applied a screening must be performed.)
 _____ **YES**, I give permission for my child to receive a dental screening.
 _____ **Yes**, I give permission for my child to receive digital x-rays, if they are necessary, which will be taken by a Licensed Dental Hygienist.

Please answer the following questions:

1. Is your child currently under a physician's care?	Yes	No
2. Is your child currently taking any medications?	Yes	No
3. Does your child have any allergies?	Yes	No

Please explain any YES answers:

Do you have any concerns or questions about your child's mouth or teeth? _____
 How often does your child brush his/her teeth? _____

Please answer the following questions.

1. Does your child have a regular dentist?	_____ Yes	_____ No
2. If yes, does your child see that dentist at least once a year?	_____ Yes	_____ No

3. My child's most recent dentist visit was within the past: (please check **one**)
 _____ 6 months _____ 1 year _____ 3 years _____ 5 years _____ Has never seen a dentist

4. How do you pay for your child's dental care? (please check **one**)
 _____ Self _____ Medicaid/Title XIX _____ *hawk-i* _____ Private dental insurance _____ Other

I understand that this consent is valid for one (1) year.

- I understand that these services are provided under the Iowa Department of Public Health and NICAO'S Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health and North Iowa Community Action Organization.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureaus of Family Health or Oral Health), the Iowa Department of Human Services, or designee.
- I understand that this screening does not take the place of a regular check-up by a dentist.
- I understand that any x-rays taken will be viewed by NICAO's Dental Director or advisory committee for examination.

Parent/Guardian Signature _____ Date _____