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| --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: | | | | Age: | | Date of Birth: |
| Address: | | | | | | Cell Phone:  Other Phone: |
| Gender:  ◻ Male  ◻ Female | What is your child’s race? (select all that apply) | | | | Ethnicity:  ◻ Not Hispanic or Latino  ◻ Hispanic or Latino | |
| ◻ White  ◻ Black/African American  ◻ Native American | | ◻ Asian or Pacific Islander  ◻ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Child’s Physician: | | Child’s Dentist: | | | | Medicaid/Hawki/Insurance ID Number: |

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| 🞎 | | | |  | | --- | | Yes, I give permission for my child to receive the following Child & Adolescent Health Services by a Registered Nurse, Registered Dental Hygienist, Social Worker, or other qualified staff (edit as needed for your program): |  |  |  | | --- | --- | | * Education/Anticipatory Guidance * Assistance Getting a Doctor or Dentist | * Referral and Other Care Coordination Services * Capillary or Venous Blood Draws | | * Assistance Getting Insurance | * Lead Poisoning Risk Assessment and Education | | * Assistance Linking to Community Resources | * Emotional/Behavioral Assessment | | * Assistance Getting Transportation | * Immunizations | | * Assistance Getting Interpreter Services | * Developmental Tests | | * Other services added here | * Dental Screening and Fluoride Application | | | | | | | | | |
| 🞎 | | | **No**, I do not give permission for my child to receive services. | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Please answer the following questions:** | | | | | | | | | | | | | | | | 1. How do you pay for your child’s dental care? (please check one) | | | | | | | | | | | | | | | | 🞎 Self Pay | 🞎 Medicaid/Dental Wellness Plan Kids | | | | | | 🞎 Hawki | | | | | 🞎 Private insurance | | 🞎 Other | | 2. My child’s most recent dental visit was within the past (please check one) | | | | | | | | | | | | | | | | 🞎 6 months | | 🞎 1 year | 🞎 3 years | | 🞎 5 years | | | | 🞎 has never seen a dentist 🞎 Unknown | | | | | | | 3. List any concerns you have about your child’s mouth or teeth: | | | | | | | | | |  | | | | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 4. Does your child have a source of medical care? | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | 5. Does your child have medical insurance? | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | 6. My child’s most recent medical visit for a well-child/adolescent exam was within the past: | | | | | | | 🞎 3 months | 🞎 6 months | 🞎 12 months | 🞎 more than 1 year | | 🞎 Unknown | | | | | | | | | | | | | | | | | 7. Are your child’s immunizations up to date? | | | | | | 🞎 Yes | | 🞎 No | | | Explain: | |  | | | 8. Is your child currently taking any medications? | | | | | | 🞎 Yes | | 🞎 No | | | Explain: | |  | | | 9. Does your child have any allergies? | | | | | | 🞎 Yes | | 🞎 No | | | Explain: | |  | | | List additional medications here: | | | |  | | | | | | | | | | | | List additional allergies here: | | | |  | | | | | | | | | | |   I consent to insert agency name use of email and texting to send me scheduling, care coordination, and child health services information. | | | | | | | | | | |
|  | | 🞎 Yes | 🞎 No | Parent/Guardian  Email address: |  | Parent/Guardian  Cell phone: |  |  | |

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| * I was offered a Notice of Privacy Practices. * I understand that this consent for services is valid for one (1) year unless withdrawn in writing by parent, guardian or client (if of legal age). * I understand that the oral health services that will be received do not take the place of regular dental checkups at a dental office. * I understand that these services are provided under the Iowa Department of Health and Human Services, Maternal and Child & Adolescent Health Program. * I understand records created and maintained as part of this program are the property of the Iowa Department of Health and Human Services. * I understand that the information from these records may be shared with the Iowa Department of Health and Human Services and its agents; Title V contractors and their subcontractors; Iowa Medicaid Enterprise or designee for care coordination, audit and quality improvement, or other legally authorized purposes. | |
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| |  |  |  | | --- | --- | --- | | **Printed Name of Parent/Guardian, or Client (if of legal age)** |  | **Date** | |
|  |
| |  |  |  | | --- | --- | --- | | **Signature of Parent/Guardian, or Client (if of legal age)** |  | **Date** | |