CONSENT FOR SERVICES AND COMMUNICATIONS

Patient Name: _____ **DOB:** _____

I. Consent for Services

I, _____, being the parent/guardian of a minor under the age of 18 years, hereby give my signed consent to the Florida Department of Health to provide dental services, including any procedures or treatments determined necessary and in the best interest of the above child, according to dental accepted procedures and treatments. I understand my consent is necessary before the Florida Department of Health can provide services to anyone less than 18 years of age. I further understand that this consent will remain in effect until retracted by me in writing to the Florida Department of Health.

	Name	Relationship	Contact Number
1.			
2.			
3.			

If I'm unable to bring my child for services, I give my consent for the person(s) listed above to represent me for any procedures or treatments necessary and in the best interest of the above child.

II. Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Our practice may contact you vial email, calls to your cellular phone (including prerecorded voice messages) and/or text messaging to confirm your appointment, to obtain feedback on your experience with our healthcare team, and to provide general health/treatment reminders and information. If at any time you provide an email address and cellular phone number below, you understand that you may get these communications from our practice. you may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates or cellular phone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

☐ **I authorize** to receive txt messages and or phone calls for appointment reminders, feedback, and general health reminders/information. The Phone number is _____.

☐ **I authorize** to receive emails messages for appointment reminders and general health reminders, feedback, and information. the email address is _____.

III. Withdrawal of Consent

I decline _____ (Patient/Parent/Guardian Initials) to receive communication via text.

I decline _____ (Patient/Parent/Guardian Initials) to receive communication via cellular phone.

I decline _____ (Patient/Parent/Guardian Initials) to receive communication via email

_____ _____

Patient/Parent/Guardian's Signature **Date**

_____ _____

Witness Signature **Date**

Dental Health History

Name _____
ID No. _____
Birth Date _____

In the following questions, circle **Yes** or **No**, whichever applies. Your answers will be considered confidential.

1. Do you **(PATIENT)** have or have you **(PATIENT)** had any of the following:

Rheumatic Fever or Heart Murmur	Yes	No	Neurological Problems	Yes	No
Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
Anemia or Blood Problems	Yes	No	Liver Problems or Hepatitis	Yes	No
Sickle Cell Anemia	Yes	No	Venereal Disease	Yes	No
Excessive Bleeding or Bruise Easily	Yes	No	AIDS/ARC/HIV Positive	Yes	No
Blood Transfusions	Yes	No	Cancer	Yes	No
Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Trimester 1 2 3		
Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
Emotional Problems	Yes	No	Other _____	Yes	No

2. Are you **(PATIENT)** currently under the care of a physician (doctor)? Yes No
   If yes, list name of doctor. _____

3. Have you **(PATIENT)** been hospitalized in the last 2 years? Yes No
   If yes, why? _____

4. Are you **(PATIENT)** currently taking any medications, pills or drugs? Yes No
   If yes, list. _____

5. Are you **(PATIENT)** allergic to or have you ever experienced any ill effect from a local anesthetic (novocain), penicillin, or any drugs/pills? i.e., rash, itching or fainting. Yes No
   If yes, describe. _____

6. Have you **(PATIENT)** ever experienced any unfavorable reaction from previous dental treatment? Yes No
   If yes, describe. _____

7. Are you **(PATIENT)** currently having any dental pain or problem? Yes No
   If yes, describe. _____

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient _____ Date _____
(If patient is a child, parent or legal guardian must sign) Relationship _____

Comments by Dentist: _____

_____

_____

Signature of Dentist _____ Date _____

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