alcona health center

Caries Risk Assessment

Patient Name: _____

Birth Date: _____ Age: _____

Please answer the following question by circling the correct answer. This will help the Dentist determine the level of risk your child has for decay.

Contributing Conditions			
Does your home have City Water or Well water?	Well Water	City Water	
If you have Well Water, has it been tested for Fluoride levels?	Yes	No	
How often does your child have sugary drinks(juice, soft drinks, energy drinks, medicinal syrups)	Mainly at Mealtimes	Frequent drinking during the day.	
Does the Parents/Caregiver and/or siblings have tooth decay?	No decay in the last two years	Decay in the last 7-23 months	Decay in the last 6 months
Does your child receive regular care with a dentist?	Yes	No	

General Health Conditions		
Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	Yes	No
History of Chemo/Radiation Therapy	Yes	No
Eating Disorders	Yes	No
Child takes medications that reduce saliva in the mouth.	Yes	No

Signature of Parent/Guardian _____ Date:_____

Printed Name of Parent/Guardian_____

Alcona health center

Patient Demographics

Name: _____ DOB: _____

Address: _____ SEX: _____

_____ DR OF RECORD: _____

Phone: _____

Insurance information

Insurance Company: _____

Subscriber: _____ DOB: _____

Policy Number: _____

Additional Patient Data

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Separated ☐ Life Partner ☐ Unknown ☐

Student: Full time ☐ Part time ☐ Not in school ☐

Race: White ☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Unreported ☐

Veteran: Yes ☐ No ☐

Pharmacy: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Alcona Health Center Dental Services
Pediatric Health History Form

Patient Name: _____ Date of Birth: ___/___/____

List all Current Medications:

_____

_____

_____

List all Allergies :

_____

_____

_____

Medical History

Please mark if patient has or, had in the past, any of the following conditions:

_High Blood Pressure	_Thyroid problems	_Seizures/Epilepsy
_Low Blood Pressure	_Asthma	_Muscular Dystrophy
_Irregular heart beat	_Cough	_Prolonged bleeding
_Heart Murmur	_Cough	_Hemophilia
_Heart Disease	_ADHD	_Leukemia
_Heart Surgery	_Autism	_Sickle Cell Anemia
_Rheumatic Fever	_ODD	_Fainting Spells
_Congenital heart defects	_Sinus trouble	_Anemia
_Diabetes	_Lung Disorders	

List any other medical conditions:

_____

_____

_____

Parent/ Guardian Signature:_____Date:_____

Relationship to patient:_____

Alcona Health Center Dental Services

DENTAL REQUIRED INFORMATION AND CONSENT

Please complete this entire form or we will be unable to see your child. Thank you.

_____

CHILD'S LEGAL NAME CHILD'S ADDRESS ZIP CODE

_____

CHILD'S TEACHERS NAME GRADE

_____M_____ F_____ _____

BIRTH DATE AGE CHILD'S RACE SEX YEARLY HOUSEHOLD INCOME

_____

MOTHER'S/GUARDIAN NAME BIRTHDATE HOME PHONE WORK PHONE CELL#

_____

FATHER'S/GUARDIAN NAME BIRTHDATE HOME PHONE WORK PHONE CELL#

Dental Insurance Information

Does child have Dental Insurance YES_____ NO_____

Has your child seen a dentist in the last year? YES_____ NO_____ If yes, by who and when: _____

Child's Medicaid (10digit) Recipient identification Number _____

If your child has a Private Insurance –please fill out below this line

Name of Insured: _____ Relationship to child:_____

Insured's Birth date _____Insured's Social Security Number_____

Name of Employer _____Address _____Zip _____

Name of Dental Insurance Company _____Phone# _____Group# _____

Insurance Company Address _____City _____State _____

Enrollee ID #: _____

Consent to child's school dental treatment

I understand by signing this form and circling yes, I am indicating that I have received a copy of Alcona Health Centers "Notice of Privacy Practice". I am also consenting to have my child receive a dental care at school. If fillings, extractions, or other services are needed, I will be notified and asked to schedule an appointment at the assigned clinic or with my family dentist. The dental care that my child receives may be covered by Medicaid, Private Insurance or Sliding Fee. Obtaining duplicate services may affect benefits that you receive from private insurance, a state or federal program or a third-party provider of dental benefits. I understand that if I have questions regarding the cost or treatment, I can contact the Dental Clinic at ***989-358- 3946.***

This consent form covers the following areas for treatment at school.

1. Consent to see your child for dental treatment that is checked below twice within the school year.
2. Consent to bill your Insurance Carrier for payment. You will be responsible for any co pays or private pay.
3. Consent to release dental records as required by your Insurance Carrier.
4. Consent for Alcona Health Center to obtain data to be used as dental research.

Please check those services that you would like your child to receive below. We will proceed with only the necessary treatments. If you child is not due for a specific treatment, it will not be performed.

**If you have more than one child, separate consent forms must be completed for each child.*

___ **Preventative treatment (Dental Exam /Screening, X-rays, and Cleaning)**

___ **Fluoride**

___ **Sealants**

Yes _____ I would like my child to receive dental services at school.

No _____I would not like my child to receive dental services at school.

_____

SIGNATURE OF PARENT/GUARDIAN DATE

_____

PHONE NUMBER WHERE I CAN BE REACHED ON THE DAY MY CHILD IS SEEN