



# Registration, Health History & Consent Form

## Child's Information (only one form per child)

First Name _____	Last Name _____
Date of Birth (mm/dd/yy) _____ <input type="checkbox"/> M <input type="checkbox"/> F	Dental Insurance (if any) _____
Address _____	City _____ State _____ Zip _____
Home Phone _____	
Emergency Contact _____	Phone _____

## Child's Health History

<b>Circle the appropriate answer:</b>	<b>Circle all that apply:</b>
Is a physician treating your child? <b>YES NO</b> If yes, why? _____	Asthma <b>YES NO</b>
Has your child been a patient in a hospital? <b>YES NO</b> If yes, why? _____	Heart Murmur <b>YES NO</b>
Does your child have any allergies? <b>YES NO</b> If yes, what? _____	Diabetes <b>YES NO</b>
Does your child take medications? <b>YES NO</b> If yes, what? _____	Seizures <b>YES NO</b>
Is there anything else we should know about your child? _____	HIV/AIDS <b>YES NO</b>
Has your child been seen by a dentist before? <b>YES NO</b> Please explain: _____	Heart Disease <b>YES NO</b>
	Bleeding Problems <b>YES NO</b>
	Please explain: _____ _____
	Have you already been to a GKAS screening? <b>YES NO</b>

## PARENT/GUARDIAN Signature

I certify that I have read and understood the above questions. The information that I have given is correct to the best of my knowledge. I will not hold the New Jersey Dental Association, New Jersey Dental School or any other participating sites of the *Give Kids A Smile!* program or any member of the staff responsible for any errors or omissions I have made in the completion of this form. I also authorize the doctors, dental staff and dental students to perform the necessary dental services that my child may need including, but not limited to, cleanings, fluoride, sealants, x-rays, anesthesia, pulpotomies, extractions, and fillings.

**NAME OF PARENT/GUARDIAN:** \_\_\_\_\_  
**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_