I-Smile™ Consent Form and Release of Information

Taylor County Public Health
405 Jefferson St / Bedford, IA

Child's name (Printed)	Male/ Female	Age:	Date of Birth / / mo day year
Address: City, State, Zip:		Phone:	
Child's physician: Date of last visit mo day year		Ethnicity (circle all that apply) White Hispanic American Indian Black Hawaiian American	
Child's dentist: Date of last visit: mo day year		Medicaid ID number:	
Family Size: Estimated monthly income:		Translator: Yes No	

_____ **YES**, I give permission for my child to receive a dental screening and fluoride application.
_____ **NO**, I do not give permission for my child to receive a dental screening and fluoride application.

1. Is your child currently taking any medications? Yes / No
2. Does your child have any allergies? Yes / No

Please explain any YES answers or special needs: _____

1. What are your child's feeding/snacking habits: (circle all that apply)
   Bottle/nursing sippy cup pop/sugary drinks candy high sugar snacks
2. What are your child's fluoride sources? (circle all that apply) city water well water bottled water other_____
3. My child's most recent dentist visit was within the past: (please circle one)
   6 months 1 year 3 years 5 years Has never seen a dentist
   Recent dental problems/concerns_____
   Brushing frequency _____
4. Have the child's parents or siblings had tooth decay in the past? ____yes ____no
5. Do you have any barriers to getting dental care? (please circle one)
   Location of dentist Transportation Cost No Barriers Other (explain)_____
6. How do you pay for your child's dental care? (please circle one)
   Self Medicaid/Title XIX hawk-i private dental insurance Other_____

- I received a Notice of Privacy Practices on _____. (*insert date)*
- I understand that this consent is good for one (1) year unless withdrawn in writing by parent or guardian.
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office or a medical check-up by a doctor. No x-rays will be taken.
- I understand that these services are provided under the Iowa Department of Public Health, 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.
- 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 Delivery Systems), the Iowa Department of Human Services, or designee.

X _____
Parent/Guardian Signature **Date**

I voluntarily authorize Taylor County Public Health Agency and its subcontractors: Page County Public Health; PHN Services of Montgomery County; SW Iowa Home Health to release, obtain, or exchange information with the following: physicians, primary care practitioner, dentists, preschool/daycare, school nurse, WIC, (other, specify)_____. This release does not authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

X _____
Parent/Guardian Signature **Date**

If you need assistance in locating a dentist or paying for your child's dental care, please contact Tara Weed, RDH, at Taylor County Public Health (712) 523-3405 or 1-800-425-0051.

Approved 4/13