Consent to Treat Patient without Parent/Legal Guardian Present for Dental and/or Medical Services

❖ Authorization:

I have the legal right to preauthorize Katy Trail Community Health and its personnel to deliver the below indiciated services to my child. These services may include, but are not limited to dental examination, prophylaxis (cleaning), fluoride application, oral x-rays, and treatment planning as recommended.

I _____ (print parent/legal guardian name), request and authorize Katy Trail Trail Community Health and its personnel to deliver the indicated services to the child named below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

Child's Name: _____ Child's birthdate:_____

❖ Services that may be delivered:

I agree to my child receiving the below school based services while they are in school, without me present:

_____ **Dental Services**
(Initial)

❖ Limitations:

Identify any specific limitations on the types of services/treatment for which this authorization is given:

_____

_____

❖ Communication:

_____ By initialing here, I give permission for the KTCH dental/medical provider providing services to my child, to communicate with the school personnel regarding the treatment or services relevant to their needs, if necessary. This communication consent will expire one year from the date of signature below unless indiciated otherwise. You understand that you can contact the clinic at any time to revoke this acknowledgement prior to that date.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **Relationship to Patient:** _____

Katy Trail Community Health

REQUIRED HEALTH HISTORY INFORMATION FOR SERVICES

PATIENT NAME: _____ *DOB:* _____ *Today's Date*_____

Primary Medical Provider: _____ *Last Visit:* _____

Tobacco Usage: (smoke or smokeless): ☐ Never used tobacco ☐ Daily tobacco user ☐ Ex-tobacco user

Have you ever been diagnosed with, or treated for any of the following? **(Check all that apply):**

☐ Abnormal bleeding	☐ Diabetes Type I	☐ Hypertension (high blood pressure)
☐ Acid Reflux	☐ Diabetes Type II	☐ Hypotension (low blood pressure)
☐ ADHD	☐ Drug Abuse	☐ Joint Replacement; Type_____
☐ Alcohol Abuse	☐ Emphysema	☐ Kidney Disease
☐ Anemia	☐ Epilepsy	☐ Lupus
☐ Anxiety	☐ Fainting Spells	☐ Mitral Valve Prolapse
☐ Artificial Bones/ Joints	☐ Gestational Diabetes	☐ Non- Epileptic Seizures
☐ Artificial Heart Valves	☐ Glaucoma	☐ Obesity
☐ Asthma	☐ Heart Attack	☐ Osteoporosis
☐ Autism- mild	☐ Heart Disease	☐ Psychiatric Problems
☐ Autism-severe	☐ Heart Murmur	☐ PTSD
☐ Behavioral Issues	☐ Hemophilia	☐ Rheumatic Fever
☐ Cancer	☐ Hepatitis A	☐ Rheumatoid Arthritis
☐ Congenital Heart Defects	☐ Hepatitis B	☐ Scarlet Fever
☐ Congestive Heart Failure	☐ Hepatitis C	☐ Shortness of Breath
☐ COPD	☐ HIV/AIDS	☐ Tuberculosis
☐ Coronary Artery Disease (CAD)	☐ Hyperlipidemia (high cholesterol)	
☐ Other _____		

☐ Currently Pregnant, Due Date: _____ ☐ Currently Nursing

Are you currently taking medications? (List any medications that you are currently taking):

_____

_____

_____ ☐ *No Current Medications*

Are you allergic to LATEX? _____ ***If yes, what kind of reaction?*** _____

Office Use Only: If yes----- Enter in tooth chart under allergies AND create "pop-up" note

Enter and Drug/Food Allergies	*Reaction*

☐ *No known Drug/Food allergies*

Have you had any recent surgery and/or hospitalizations? ☐ No ☐ Yes- Date of hospitalization:_____

If yes, please explain: _____

Updated: 8/29/22 mtl