



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 indicated services to my child. These services may include, but are not limited to a routine annual wellness medical services, age appropriate immunizations and any other treatment plan as recommended.

I _____ (print parent/legal guardian name), request and authorize Katy 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:

_____ Medical 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 indicated 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:** _____

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):

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

<u>Enter and Drug/Food Allergies</u>	<u>Reaction</u>
<input type="checkbox"/> No known Drug/Food allergies	

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

If yes, please explain: _____