



**Parent: Please return these forms to
Centre Volunteers in Medicine by
April 26, 2019 in order for your child
to receive an appointment.**

***We will call you with an
appointment as soon as we
complete the event schedule.***

**BE SURE TO ATTACH A COPY OF YOUR MOST RECENT FEDERAL TAX RETURN OR
AT LEAST ONE PAYSTUB FOR EACH PERSON WITH A HOUSEHOLD INCOME WITH
THIS APPLICATION**

**Send to:
Centre Volunteers in Medicine
Attention: Kristi Mattzela -- GKAS
2520 Green Tech Drive, Suite D
State College, PA 16803**

CENTRE VOLUNTEERS IN MEDICINE

GIVE KIDS A SMILE AND VISION FOR THE FUTURE 2019 CONSENT FORM

Dear Parents/Guardians,

We welcome you in joining us for our *Give Kids A Smile* event to be **held May 10th**. Services will be provided to Centre County kids without dental and vision insurance. At the event **ALL** children will receive **ALL** the following services:

- ✓ Dental Exam
- ✓ X-rays
- ✓ Cleaning
- ✓ Sealants
- ✓ Brushing and Flossing Instructions
- ✓ Comprehensive orthodontic evaluation
- ✓ Fluoride Treatment
- ✓ Restoration of Decayed Areas
- ✓ Extraction of non-restorable teeth
- ✓ Vision exam (glasses if needed)
- ✓ Voucher for a free hearing screening

Please sign below to acknowledge that you give permission for your child to receive **ALL** of the free services listed above. This acknowledges that you received a copy of this consent form. **We will contact you with your appointment date and time closer to the day of the event.**

If you prefer your child NOT receive ALL services or if your child has urgent or immediate dental problems, attendance at this event is not for you. Please call Centre Volunteers in Medicine at (814) 231-4043 to learn about access to customized dental services.

*****IT IS YOUR RESPONSIBILITY AS A PARENT/GUARDIAN TO PROVIDE ANY PRE-MEDICATIONS YOUR CHILD MAY REQUIRE PRIOR TO DENTAL WORK. YOU WILL BE ASKED TO PROVIDE THE NAME, DATE AND TIME PRE-MEDICATION WAS ADMINISTERED WHEN YOU CHECK-IN THE DAY OF THE EVENT. (If you do not know if your child needs pre-medication or not, please ask your doctor/pediatrician.)**

Please return all forms AS SOON AS POSSIBLE and NO LATER than April 26 to:

Centre Volunteers in Medicine
Attention: Kristi Mattzela -- GKAS
2520 Green Tech Drive, Suite D
State College, PA 16803

Appointment Contact Information:

NAME	PHONE #	EMAIL

Parent/Guardian Signature: _____ Date: _____

Centre Volunteers in Medicine

2520 Green Tech Drive, Suite D
State College, PA 16803
Phone: 814 231-4043
FAX: 814 231-5274

Dental Registration Form

Patient Information

Name: _____ Date of birth: _____ Age: _____ Sex: M F

Address: _____ Social Security Number: _____

City: _____ Medical insurance: Yes No

State: _____ ZIP: _____ If Yes, what type: _____

Phone: () _____ Dental insurance: Yes No

If Yes, what type: _____

If under 18, parent/guardian name: _____ Phone (if different from above): () _____

Patient Dental History

Date of last dentist visit: _____ For what service? _____

Dentist seen: _____ Date of last cleaning: _____ Date of last x-rays: _____

Any unhappy dental experiences? Yes No Any mouth habits (thumbsucking, nail biting, pacifier, etc.)? Yes No

If Yes to any of above, please explain: _____

Brush teeth daily? Yes No Floss teeth daily? Yes No Have fluoridated water? Yes No Have well water? Yes No

Please mark (x) if you had any of following problems:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity to biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in mouth

What is your main dental concern? _____

Patient Medical History

Date of last physician visit: _____ Pregnant? Yes No Not applicable

Physician name: _____ Have child less than 1 year of age? Yes No

For what service/reason? _____ Do you smoke? Yes No

Do you chew tobacco/snuff? Yes No

Please mark (x) if you had any of following problems:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Any Operations
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Any hospital stay
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Kidney/Liver Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Handicaps/Disabilities
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Other
<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Hearing Impairment	

Please explain any medical problems: _____

Please list all medications currently taking: _____

Please list all allergies or anything (food , drug, or material) you have had a bad reaction to: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any change in my/my child's status. I also authorize the dental staff to perform the necessary services l/my child may need.

Signature of patient/parent or guardian: _____ **Date:** _____

Patient Name (*Please Print*)

Household Members:

Number of individuals in household (number of people on tax return): _____

Number of Adults: _____ Number of Children: _____

Household Income:

Name of household member	Type of Income	Amount of Income monthly
	Total	\$

Signature

Parent signature:

Date:



CVIM Publicity Consent Form

I hereby give Centre Volunteers in Medicine (CVIM), a non-profit provider of free health care, permission to use my or my minor child's likeness in photography for publications, promotional purposes, website, media press releases and coverage, and any other such purpose on behalf of Give Kids a Smile Day.

My signature releases CVIM from any liability caused by blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said pictures, or in any processing thereof.

I understand that I or my minor child (under age 18) will not receive compensation for the use of this likeness in any form.

Description of project: Give Kids a Smile Day and Vision for the Future Programs

Date: _____

Child's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Thank you very much for your participation and supporting CVIM.