HELPING HANDS DENTAL SERVICES
A nonprofit organization

Mobile Dental Clinic
Medical/Dental History Form
Children (0 – 18 years)

_____ _____ _____ _____/_____/_____ **Male**:☐ **Female**: ☐

Patient First Name: **Patient Last Name:** **Suffix:** **Birth Date:**

(_____)_____-_____ _____ _____ IL _____

Phone Number **Home Address (include unit/apt number if applicable)** **City** **Zip Code**

_____ _____ _____

Dental Insurance Name **Member ID Number** **Responsible Party Email Address**

Family Physician's Name: _____ **Physician's Phone**: _____

1. Is patient under treatment by a physician? ☐ Yes ☐ No
2. Has this patient had any serious illnesses, surgeries or been hospitalized? ☐ Yes ☐ No
   If yes, please explain_____
3. Please list any medications & the dosage this patient is taking:_____
4. Allergies: ☐ None ☐ Penicillin ☐ Sulfa Drugs ☐ Latex ☐ Codeine ☐ Local Anesthetic
   ☐ Other antibiotics _____ ☐ Artificial food, flavors, colors ☐ Other _____
5. Has this patient's physician/dentist ever prescribed antibiotics prior to a dental appointment? ☐ Yes ☐ No
6. Is this patient disabled? ☐ No ☐ Yes If yes, please describe: _____
7. Has this patient ever had any history of the following? If yes, check the appropriate space. If No, check here ☐

☐ Autoimmune disease	☐ Heart Valve Replacement or Mitral Valve Prolapse	☐ HIV
☐ Anemia	☐ Heart Murmur	☐ Psychiatric Disorders
☐ Asthma	☐ Kidney or liver disease	☐ Diabetes
☐ Bleeding disorders	☐ Lung disease / Bronchitis	☐ Tuberculosis
☐ Childhood disease	☐ Seizures/ Epilepsy/ Fainting	
☐ (Mumps, measles)	☐ Other: _____	

8. Has this patient ever had any history of the following oral habits?
   ☐Pacifier ☐ Mouth Breathing ☐ Grinds/Clench Teeth ☐ Thumb/Finger Sucking ☐ Nail Biting
9. Has this patient ever had an injury to the head, face, or jaw? ☐ No ☐ Yes; Explain_____
10. What is the drinking water source for this patient? Please check the appropriate space.
    ☐ City water ☐ Well water ☐ Bottled Water ☐ Filtered Water ☐ Unsure
11. Is this patient experiencing any of the following: ☐ Pain/Discomfort ☐ Swelling ☐ Toothache(s)?
12. How does this patient feel about going to a dentist? Please check one: ☐ Scared ☐ Nervous ☐ Just Fine

For Women ONLY:

Are you pregnant? ☐Yes ☐ No If yes, what month are you due? _____ Are you nursing? ☐Yes ☐ No

I certify that I have read and understood the above questions. To the best of my knowledge the above information is correct and accurate. I will not hold Helping Hands Dental Services, treating dentist(s) or any member of the dental staff responsible for any errors or omissions I may have made in the completion of this form. I understand that it is my responsibility to inform my child's dentist when there is a change in my child's medical condition, or when there is a change in the responses to any of the above questions. A copy of our Privacy Policy is available upon request.

Print Parent/Guardian Name _____ **Signature** _____

Relationship to Patient _____ **Date**_____

Revised 8.21.2025

Mobile Dentistry Consent, Release of Liability, and Authorization Form

Patient First Name:	Patient Last Name:	Suffix:	Birth Date:
_____	_____	_____	_____/_____/_____

As the parent/guardian of the above named student, I understand that licensed dentists will be coming to my child's/ward's facility in the near future to provide a DENTAL EXAM/SCREENING and as needed a DENTAL CLEANING, FLUORIDE TREATMENT and DENTAL SEALANT(S) at NO COST to students or their families in the facility. Dental sealants, in addition to regular brushing and flossing, protect your child's/ward's teeth from DECAY. Dental Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don't hurt. PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.

I understand that in consideration for my child's/ward's participation in the PROGRAM, and as evidenced by my signature below, I hereby release and hold harmless Helping Hands Dental Services, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the PROGRAM whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of Helping Hands Dental Services, its departments, including the Department of Public Health, its employees, officers, contractors, volunteers, agents, or representatives.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the Helping Hands Dental Services is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. This signed consent form is valid for 365 days from the date that it is signed by the child's/ward's parent or guardian.

As the parent or guardian of the above — named child or ward, I consent for my child or ward to participate in the Mobile Dental Clinic, which includes a dental exam/screening and as needed a dental cleaning, fluoride treatment and dental sealant(s) and the receiving of Quality Assurance exams. I authorize the dental provider to use my child's or ward's Medicaid, ALL KIDS and private dental insurance number for billing purposes only. I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child or ward will not receive any services under this program.

Parent/Guardian Signature _____ **Date** _____

Mobile Dentistry Authorization - HIPPA

By signing below, I understand that I am giving my authorization to the dental provider to use and/or disclose my child's/ward's protected health information, to the following person(s) or organization(s) for the purposes of reports, documentation of oral health trends, and Medicaid billing: City of Illinois Department of Healthcare and Family Services, 201 So. Grand Avenue East, Springfield, IL, 62763; Illinois Department of Public Health - Oral Health Division, 535 W. Jefferson Street, 2nd Floor, Springfield, IL, 62761, and Infant Welfare Society of Chicago (IWS), 3600 W Fullerton Ave, Chicago, Oak Park-River Forest Infant Welfare Clinic, 320 Lake Street, Oak Park, IL 60302.

Helping Hands Dental Services may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization. This Authorization is voluntary, and I may refuse to sign it. I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) and federal privacy regulations. I may revoke this Authorization in writing by sending notice to the HIPAA Privacy Officer, Helping Hands Dental Services, 2447 W. 79th Street, Chicago, IL 60652. Revocation is not effective with respect to actions taken prior to the revocation. This authorization is valid for 365 days from the date that it is signed by the child's/ward's parent or guardian.

Parent/Guardian Signature _____ **Date** _____