Your Kids Can Receive Dental Care While at School



Bagdad DENTAL

Earning Your Trust with a Smile!

Follow these three easy steps to get your child the dentistry that they need:

1. Fill in all of the fields below in pen.
2. Sign next to the ✕ at the bottom of the page.
3. Have your child return this form to his or her teacher.

School, Patient & Insurance Information

Student Name_____ Teacher_____ Room No._____

Student Date of Birth_____/ _____/ _____ Gender: M F P.O. Box_____

Parent/Guardian_____ Relationship to Student_____

Home Phone_____ Cell Phone(s)_____

Parent/Guardian Email_____

Insurance Company_____ ☐ My Child Does Not Have Dental Insurance

Employee's Name_____ SS#_____ Employee's DOB _____/ _____/ _____

Employee's Relationship to Student_____ People Soft Number_____

Group Number_____ Policy Number_____

Health History (Circle "Yes" or "No") - Please Notify Us of Any Medical Changes

Abnormal Bleeding	YES	NO	Epilepsy	YES	NO	Liver Problems	YES	NO
ADHD	YES	NO	Heart Problems	YES	NO	Kidney Problems	YES	NO
Artificial Joints, Pins, etc	YES	NO	Hepatitis	YES	NO	Respiratory Disease	YES	NO
Asthma	YES	NO	High Blood Pressure	YES	NO	Seizures	YES	NO
Blood Disorder	YES	NO	History of Cancer	YES	NO	Skin Rash	YES	NO
Congenital Birth Defects	YES	NO	HIV/AIDS	YES	NO	TB	YES	NO
Diabetes	YES	NO	Latex Allergy	YES	NO	Thyroid Problems	YES	NO

_____ Surgeries

_____ Allergies to Medications

_____ Medications

_____ Other Conditions

I authorize Dr. J. Brett Mangum, DDS, affiliated practice to provide dental care which may include dental exams, x-rays, cleanings, fluoride, and sealants at school without my presence unless I withdraw consent. I authorize and direct Dr. J. Brett Mangum, DDS to bill and collect payments from any insurance that covers the services provided to this patient, which shall be applied to the patient's benefits. If there will be a cost to me, then I will be called first to approve or decline. I acknowledge receiving a notice of privacy practices attached to this consent form. As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES." As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

✕ Sign Here_____ Date_____

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