

**Outreach Clinic Permission Form – please print clearly and complete all areas**

Child's Name \_\_\_\_\_ MA Primewest Blue Plus Medica Headstart Sliding fee scale(apply)  
DOB \_\_\_\_\_ Gender; MALE FEMALE Insured ID # \_\_\_\_\_  
Parents/ Guardian \_\_\_\_\_ Private Insurance Co. name \_\_\_\_\_ ID# \_\_\_\_\_  
Address \_\_\_\_\_ Private Insurance in name of \_\_\_\_\_ DOB \_\_\_\_\_  
Phone \_\_\_\_\_ Private Insurance Co address \_\_\_\_\_

**Medical/Dental History:**

Physician/Clinic \_\_\_\_\_ Health Concerns/Conditions \_\_\_\_\_  
Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Is Child being treated for anything at this time? Yes No If yes, What \_\_\_\_\_  
Recent Hospitalization: \_\_\_\_\_ Surgeries: \_\_\_\_\_  
Last dental visit \_\_\_\_\_ What was done \_\_\_\_\_ Where \_\_\_\_\_  
Is this your regular dentist? \_\_\_\_\_ If yes, will you continue going there? \_\_\_\_\_ Any dental concerns \_\_\_\_\_

**Notice of Privacy Practices**

You have privacy rights under the Minnesota Government Data Practice Act and the Federal Health Insurance Portability and Accountability Act (HIPPA). These laws protect your privacy, but also let us give information about you to others if a law requires it. A complete notice with all details is available upon request from the following provider of services.

**Permission**

I give permission to Caring Hands Dental Clinic staff to provide the following services for the above named patient. I have reviewed the Notice of Privacy Practices. Circle all that apply:

Oral Examination    Xrays(if needed)    Cleaning    Fluoride Varnish    Oral Hygiene Instructions

I also give permission for the patient's dental/health information to be shared with the following; please X those

with permission.    Headstart \_\_\_    Social Service \_\_\_    Public Health \_\_\_    County Family Services \_\_\_  
School Health Service \_\_\_    Family Services Collaborative \_\_\_

Others, please list \_\_\_\_\_

Parent/ Guardian  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This permission is in effect for 18 months unless cancelled sooner.

**CLINIC USE ONLY**

❖ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Referral: YES NO

Oral Exam    Cleaning    Fluoride Varnish    Oral Hygiene Instructions    Xrays

Notes: \_\_\_\_\_