Polished, LLC Health History

Child's Information (Please print):

Child's Name: _____ _____ M ☐ F ☐ **Child's Birthday**: ____/____/____
(first) (last) (month) (day) (**birth year**)
School: _____ Grade: _____ Room: _____ Teacher:_____
Child's primary language: _____Parent's primary language:_____
Parent's name and address: _____
Email_____ Parent's day time phone: _____

Dental Information:

1. Date of last dental cleaning: _____
2. My child's only dental prevention is at school YES☐ NO ☐ ___
   If **YES** do you need a Polished, LLC dentist to examine your child YES☐ NO ☐
3. My child has a local dentist YES ☐ NO ☐ Dentist name: _____
4. I would like help finding a local dentist YES ☐ NO ☐
5. My child needs to take antibiotics before having dental treatment ☐YES Why?_____ ☐ NO
6. Please tell us about your child's dental experience._____

Medical Information:

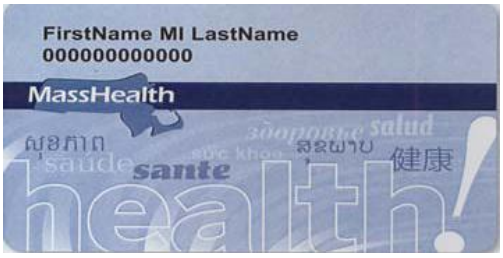
1. My child has had serious health problems YES ☐ NO ☐
2. My child is under a doctor's care now. YES ☐ for_____ NO ☐
3. My child has now or had before: Anemia ☐ Asthma ☐ Convulsions ☐ Diabetes ☐ Epilepsy ☐Seizures☐
   Glaucoma ☐ Heart Murmur ☐ Heart Problems☐Hepatitis ☐ Kidney/ Liver ☐ Rheumatic Fever ☐
   Immune Disorder /HIV/ AIDS ☐ Tuberculosis☐ Other please explain:_____
4. My child is taking medicine YES ☐ name of medicine_____ NO ☐
5. My child is allergic to: Penicillin☐ Antibiotics ☐ Aspirin ☐ Latex ☐ Foods ☐ Other:_____

Other Information:

Child's race: Black/ African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐
Native Hawaiian/ Pacific Islander ☐ More than one race ☐ I do not wish to answer ☐
Child's Ethnic Origin: Hispanic ☐ Non Hispanic ☐ I do not wish to answer ☐

Insurance Information

My child has the following dental insurance: →



☐ **No Dental Insurance**

☐ **MassHealth** RID Number: _ _ _ _ _ _ _ _ _ _ _ _ _

☐ **Delta** ☐ **BC/BS** ☐ **Other** _____

Individual Policy#_____

Group Policy # _____

Subscriber Information

Subscriber Name: _____ Subscriber ID: _____

Subscriber Date of Birth: Month_ _ Day_ _ Year_ _ _ _ Employer Name:_____

I agree that the above health information is correct.
I have read and received a copy of the Polished LLC privacy policy.
I give permission for Polished LLC to provide preventive care and to bill my insurance for care provided.

SIGN HERE Parent/Guardian _____**Date:** _____

Contact Information

Boston and points south contact: Ellen Gould RDH email: gould.ellen@gmail.com; phone (508) 237-5378
North and west of Boston contact: Valerie Osborn RDH valerie.rdh@gmail.com phone (617) 571-1697
Cape Cod and Islands contact: Lynn Couto RDH lcoutordh@yahoo.com phone (508) 789-0703

PLEASE TURN PAPER OVER AND FILL OUT SIDE 2 →

INFORMED CONSENT

Purpose:

Polished, LLC may provide the following preventive care services at your child's school:

1. **A dental hygiene evaluation or dental examination:** Check the teeth and mouth (up to 2 times in the school year)
2. **Tooth cleaning:** To remove plaque and other deposits (up to 2 times in the school year)
3. **Fluoride treatment:** Painted on the teeth to protect them from cavities (up to 4 times in the school year)
4. **Sealants:** Placed on the chewing surface of the teeth to prevent cavities
5. **Health education:** To teach children how to care for their teeth
6. **Temporary fillings:** This is a temporary filling to decrease sensitivity and to maintain your child's normal bite. Your child will need further care from his or her dentist.

If your child needs a dentist, we will help you find a local dentist and get an appointment for care.

The care provided by the Polished, LLC dental hygienists is to prevent dental disease and is not a substitute for dental care by a dentist.

Safety:

The materials used are the same as those in dental offices.
Licensed dentists and/or dental hygienists will provide all of the care listed above.
Safety standards include: sterilized instruments, wearing gloves and face masks.
All materials are latex free.

Privacy Policy

I understand that results of the dental or dental hygiene examination and care provided may be shared with the school health office and/or my dental insurance provider to verify services that were provided, or as required by law or as I permit in writing.

Emergencies:

Polished, LLC staff will follow the appropriate school protocols for emergencies.

Withdrawal:

I understand I may continue to obtain dental care through any other provider.
I understand participation is voluntary and I may withdraw my child in writing at any time.

Questions:

If you want any further information about this program or have any questions please contact
Ellen Gould RDH 508-237-5378, Valerie Osborn RDH 617-571-1697, Lynn Couto RDH 508-789-0703

Agreement:

I read and understood this Consent Form. I agree to allow my child to participate in this program and I authorize the dental program to provide a written summary of the services provided to an official designated by my child's school. I understand that treatment provided may affect future rights and benefits of private insurance, Medicaid, or the children's health insurance program.

Child's First Name: _____Child's Last Name:_____

Childs Birth Date: Month_____Day____Year____

Parent/Guardian First Name:_____Parent/Guardian Last Name:_____

I have read and received a copy of the Polished, LLC privacy policy.

Signature:_____ Date:_____

PLEASE TURN PAPER OVER AND FILL OUT SIDE 1 →