Give Kids A Smile 2023

Watertown area dentists are hosting a free Give Kids A Smile event on February 3, 2023 for children ages 0-18 in Codington and Hamlin counties. This event focuses on families who lack dental insurance, Medicaid or the finances to receive dental care. If you are interested in signing up for this event or have questions, please contact Kay at Lake Area Pediatric Dentistry

(605)753-5437

Deadline for sign-up is January 25, 2023

Darles a los niños una sonrisa 2023

Los dentistas del área de Watertown organizarán un evento "Darles a los niños una sonrisa" el 3 de febrero de 2023 para niños de 0 a 18 años en los condados de Codington y Hamlin. Este evento se enfoca en las familias que carecen de seguro dental, Medicaid o las finanzas para recibir cuidado dental. Si usted está interesado en inscribirse en este evento o tiene preguntas, comuníquese con Kay en Lake Area Pediatric Dentistry
(605) 753-5437.

La fecha límite para inscribirse es el 25 de enero de 2023.

Medical and Dental History Form

Please complete the following form so we may better serve your child

Child's Name:________________________ Date of Birth:__________ Gender: ___Male ___Female

Has your child had any of the following? (Please X each box)	Yes	No	**Comments & Dates on all Yes**
Heart Murmur – If yes, we **must** have a report from MD			
Congenital Heart Disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular, or other Endocrine Disease			
Liver Disease, Hepatitis, Jaundice			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures, Convulsions, Loss of Consciousness			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Cancer			
Speech Disorder			
Hearing Disorder			
Sight or Eye Disorder			
Frequent Headaches			
Mental, Emotional, or developmental Delays			
Autism, ADHD, Genetic Disorder/Syndrome (please state)			
Frequent Infections			
Has your child ever received blood/blood products?			
Has your child ever been hospitalized?			
Has your child ever been seriously ill?			
Has your child ever had a significant injury?			
Has your child ever had surgery?			
Does your child take any medications at this time?			
Is your child allergic....................to any materials?			
....to any medications?			
.....to any foods, environmental pollutants, animals?			

Are there any other problems, diseases, or medical conditions that we should know about in order to care for your child? __NO __YES Please List:____

Who is your child's primary physician or physician's group?

Name__________________________ In______________________ Phone____________________

Has your child had any of the following?	Yes	No	Comments on all Yes
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck, or have other oral habits			
Does your child have any other dental conditions			

How often does your child brush?_____________________ Last Dental Visit________________________

Special family considerations of which we should be aware:____

Responsible Party Information

Child **MUST** be accompanied by Mother, Father, or Legal Guardian.

Name ___________________________ Relationship to patient_____________________

Address _______________________________Home # __________Work # _________Cell #___________

Parent/Guardian Signature Date

_____________________________________ __________________

CONSENT FOR DENTAL TREATMENT
HIPAA

I authorize, request, and permit Dr. Thane Evans Crump and any employees under his supervision to perform any and all dental services in order to preserve and restore my child's oral health. Additionally, I authorize the use of medications, anesthetics, nitrous oxide, and x-rays deemed necessary in the course of treatment. I acknowledge the risks inherent in providing dental treatment and that although good results should be expected, the possibility and nature of complications cannot be accurately anticipated and thus no guarantee of results can be expressed or implied. I recognize that during the course of treatment unforeseen circumstances may change the diagnosis of the original condition, which would necessitate an extension of the original procedure or a different procedure.

I am aware that occasionally it is extremely difficult to perform dental treatment on a child due to lack of cooperation, which can be common in very young children and those with mental or physical disabilities. I agree to report any health changes to the dentist prior to each visit.

I authorize the use of radiographs, photographs, and treatment records for the purposes of teaching or scientific endeavors. I also authorize Lake Area Pediatric Dentistry to obtain/share any records from/with other dental or medical offices and educational facilities necessary for the care of my child.

I understand that my child, ___________________________, is **encouraged** to come back on his/her own and recommend that school age children come back on their own, if necessary **one parent per family** is allowed to come back. We ask that parents be silent observers unless we request you to give instruction, this helps prevent confusion for your child.

All *siblings must remain in the waiting room and be with a care giver* ***at all times****.*

We ask that only friendly dental terms be used when discussing appointments with your child.

This consent shall remain in full force until cancelled by either party.

X ________________________________   ____________________

Signature   Date

In 2003, the federal government implemented procedures (known as HIPAA) to protect the health information of patients. Our office will make all reasonable efforts to protect you and your child's medical and dental information, dental records, and financial information. By signing below you acknowledge that we have publicized our privacy procedures, and you are aware that a copy of such procedures was made available to you. Additionally, you authorize our office to use the information in providing support to other health care providers or financial institutions in order to expedite to the law, we are not required to honor requests. If you have further questions you may contact the US Department of Health and Human Services. Thank you.

X ________________________________   ____________________

Signature   Date