ROOM NUMBER:

Smileplus Dental Clinic
Machray School
320 Mountain Avenue
Winnipeg Manitoba, R2W 1K1
P: (204) 940-2090
F: (204) 940-1747

MACHRAY SCHOOL DENTAL PROGRAM – S.M.I.L.E.*plus* 2024- 2025

Consent for Dental Services

During the 2024-2025 school year, the Winnipeg Regional Health Authority (WRHA) S.M.I.L.E.*plus* Dental Program in conjunction with The University of Manitoba Dental School will be offering dental services to the children at Machray School.

With your permission we will provide your child with dental services from a team of dental professionals as well as dental graduate students. Our goal is to provide dental services to as many children as possible during the school year.

☐ **NO:** I do not want this child to receive dental services at the Machray School Dental Clinic.

☐ **YES:** I consent to this child being escorted from class to the Machray School Dental Clinic for dental services which may include:

- First visit including an examination, x-rays, cleaning and a treatment plan of dental services required.
- Follow-up visits which may include local anesthetic (freezing), fillings, extractions, and any other services recommended by the dentist.

I____________________ (print name), the parent or guardian whose signature follows, certify that the information provided is true and complete to the best of my knowledge.

Parent/Guardian Signature_________________________ Date:________________
Student Name:____
Address ____________________________________ Postal Code _______________
Phone Number (Home/Work/Cell) ____
Manitoba Health # ________________ PHIN # _______________________________________
Email Address:

You may have **dental coverage**. Please provide the information
DIAND (Treaty) # ___________________________________
EIA (Social Assistance) # ___________________________________
PRIVATE INSURANCE (please specify) _______________________
NO Dental Coverage ___________________________________
Please complete other side of page with your child's information! ➔

Oral Health
CONFIDENTIAL MEDICAL HISTORY

Today's Date: ___ ___ / ___ ___ / ___ ___ ___ ___ (d d / m m / y y y y)

Patient Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___ (d d / m m / y y y y)

Patient Last Name: ______________________________

Patient First Name: ______________________________

Please answer every question. Feel free to ask for help in completing this form.

MEDICAL HISTORY

Please check (✔)

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? ☐ Yes ☐ No
2. Are you presently being treated by a medical doctor? ☐ Yes ☐ No
3. Are you taking any medicine, non-prescription drugs, or herbal supplements now? ☐ Yes ☐ No
   If yes, please specify: ______________________________
4. Have you ever had any of the following diseases? **Please check (✔)**
   a) Heart Problems (e.g. murmur, angina, heart attack, pacemaker, prosthetic heart valve, rheumatic fever) ☐ Yes ☐ No

b) Stroke	☐ Yes	☐ No	k) Thyroid Disease	☐ Yes	☐ No
c) High/Low Blood Pressure	☐ Yes	☐ No	l) Diabetes	☐ Yes	☐ No
d) Blood Disorders	☐ Yes	☐ No	m) Cancer	☐ Yes	☐ No
e) Lung Disease (e.g. asthma)	☐ Yes	☐ No	n) Epilepsy or Seizures	☐ Yes	☐ No
f) Tuberculosis	☐ Yes	☐ No	o) Mental or Nervous Disorder	☐ Yes	☐ No
g) Kidney Disease	☐ Yes	☐ No	p) Alzheimer Disease/Dementia	☐ Yes	☐ No
h) Liver Disease (e.g. hepatitis/jaundice)	☐ Yes	☐ No	q) Venereal Disease/STD	☐ Yes	☐ No
i) Arthritis/Rheumatism	☐ Yes	☐ No	r) AIDS/HIV/Immune Problem	☐ Yes	☐ No
j) Joint Replacement (e.g. hip/knee)	☐ Yes	☐ No	s) Frequent Drug/Alcohol Use	☐ Yes	☐ No

5. Do you have any physical/mental/behavioral/developmental disorders? ☐ Yes ☐ No
   (e.g. cleft palate, autism, ADHD, FASD)
   If yes, please specify: ______________________________
6. Do you smoke or chew tobacco or other products? ☐ Yes ☐ No
7. Do you have any allergies? (e.g. medication, freezing, or latex) ☐ Yes ☐ No
   If yes, please specify: ______________________________
8. Do you have any disease or problem not listed above that you think we should be aware of? ☐ Yes ☐ No
   If yes, please specify: ______________________________
9. **ADOLESCENT AND ADULT FEMALES ONLY:**
   a) Are you pregnant? ☐ Yes ☐ No
   b) Are you breastfeeding? ☐ Yes ☐ No
   c) Are you taking any birth control pills? ☐ Yes ☐ No

DENTAL HISTORY

1. When was your last dental visit? ☐ within past year ☐ 1 to 5 years ☐ more than 5 years ☐ this is my first visit
2. Do you have any dental problems now? (e.g. toothache, swelling, bleeding gums, jaw joint problem) ☐ Yes ☐ No
   If yes, please specify: ______________________________
3. Are you unusually nervous/anxious about dental treatment? ☐ Yes ☐ No

Provider's Initials ____________

Office Use Only. MEDICAL UPDATE (to be completed if current Medical History is ≥ 6 months old)
Ask Patient: ***"Has there been any change in your health or medications since this medical history was completed?"***

Date	Unchanged	Changed (new form required)	Provider's Initials
____________ (dd/mm/yyyy)	☐	☐	________
____________ (dd/mm/yyyy)	☐	☐	________
____________ (dd/mm/yyyy)	☐	☐	________

Winnipeg Regional Health Authority — Office régional de la santé de Winnipeg — Caring for Health — À l'écoute de notre santé
University of Manitoba — Faculty of Dentistry — Centre for Community Oral Health
Mount Carmel Clinic