Community Health Center of Southeast Kansas

Consent for In-School Dental Care

The Community Health Center of Southeast Kansas will be providing in-school dental care including sealants, fluoride, cleanings, exams, x-rays and fillings. There is no out-of-pocket cost to you for this service. However, insurance (if available) will be billed. Please select the services that you **DO WANT** your child to receive:

Preventative Services Include:

☐ Cleaning

☐ Fluoride

☐ Sealants

Restorative Services include all of these services:

☐ Filling, X-Rays, and Exam

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:

Date of Birth_________________________ Gender: ☐ Male ☐ Female

School Name____ Teacher____________________ Grade _______

Race/Ethnicity (check all that apply)

☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Other

☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander

Parent/Guardian Information:

Name____________________________________ Date of Birth ______________________

Address_________________________________ City________________ State_______ Zip____________

Phone Number ____________________________

☐ **KanCare (Amerigroup, United HealthCare, Sunflower) #** ________________________________

☐ **Medicaid (Oklahoma or Missouri) #** ________________________________ ☐ **No Insurance**

☐ **Private Dental Insurance (Please complete the following):**

Carrier _____________________________ Policy # ____________________Group #___________________

Policy Holder Name___________________ Policy Holder DOB_____________Policy Holder SSN__________________

Mailing Address for Claims (found on back of card) ____

Phone Number for Claims_______________________

Please complete the back of this form Rev. 3/2017

Medical History

Check all that apply:

☐ Artificial Heart Valve ☐ Artificial Joints Pins/Screws ☐ Asthma ☐ Congenital Heart Disorder

☐ Diabetes ☐ Heart Disease ☐ Hepatitis ☐ Seizure disorder

☐ Heart murmur ☐ Autism

☐ Other medical conditions or special health care needs: ____

____

Any Known Allergies: ☐ Latex ☐ Amoxicillin/Penicillin ☐ Other ____

Medications

Please list current medications:____

____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment?

☐ No ☐ Yes

If yes, for what condition ____

Other information

When did your child last visit a dentist? ☐ 6 months ☐ In the past year ☐ More than a year ☐ Never

Name of dentist:____

Please tell us anything we should know about previous dental experiences that would help us better treat your child:

____

I am the parent or legal guardian/custodian and give my consent for the above named child to receive dental services provided by CHC/SEK. I confirm that the above health information is accurate to the best of my knowledge and I will contact CHC/SEK if any changes occur. I understand that all patient information is protected and will only be exchanged with staff employed by CHC/SEK and the school. I authorize CHC/SEK to release the information necessary to process insurance claims and authorize payment directly to CHC/SEK.

Parent/Guardian Signature______________________________ **Date**____________

If you have any questions, please contact the Dental Outreach Coordinator at **620-240-5657** or by email at **outreach@chcsek.org**

Kansas Department of Health and Environment

Kansas Bureau of Oral Health

Rev.3/2017