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 and cleanings. 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:

☐ Cleaning ☐ Fluoride ☐ Sealants

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_____

Kansas Department of Health and Environment — Kansas Bureau of Oral Health

Please complete the back of this form

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