Dental Consent Form

Community Health Center of Southeast Kansas will be providing dental services at your child's school this year. All children are invited to participate in the program, but the program has a special focus on those children not receiving services elsewhere. No child will be denied services based on insurance status or ability to pay. However, insurance (if available) will be billed.

School Name:____

Student Name:____**DOB**:___________**Grade**:______ **Gender**:_______

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race

Ethnicity (circle one) Hispanic or Latino OR Not Hispanic or Latino

Does the child have dental insurance? (circle one) YES OR NO

If yes, complete the insurance section below. We will bill your insurance for services provided.

- ☐ KanCare (Amerigroup, United Health Care, Sunflower) #____
- ☐ Medicaid (Oklahoma or Missouri)#____
- ☐ No Insurance
- ☐ Commercial/ Private Insurance

Subscriber Name____DOB_______________SSN#____________________

Insurance Company__________________________________Policy#_______________________Group#_____________

Parent Guardian Name______________________________________Daytime Phone #____________________________

Address____City__________________State_________Zip_________

As parent or legal guardian of the patient named above, I give Community Health Center of Southeast Kansas permission to provide my child with the following services**: Preventative Services include: Cleaning, Sealants, Fluoride Treatment, Silver Diamine Fluoride Treatment and Interim Fillings. Restorative services (if available) include: Exam, X-Rays and Fillings**. This consent is valid for one year from the Parent/ Guardian Signature date below.

Please list the services below you do **NOT** want your child to receive:

____

Parent/Guardian Signature____ **Date**______________________________

Please complete and sign the Medical History Form on the other side

Medical History Form

Student Name:____ DOB____________________________

When did your child last visit a dentist:

- In the past year
- More than a year
- Never

Why did your child visit the dentist?

- Checkup
- Cleaning
- Pain
- Filling
- Tooth pulled
- Other

Medical History: Please check all that apply

- Heart Murmur
- Artificial Joints/ Pins/Screws
- Seizure Disorder
- Ashtma
- Artificial Heart Valve
- Asthma
- Diabetes
- Hepatitis
- Heart Disease
- Congenital Heart Disorder
- Other

Allergies:

- Latex
- Amoxicillin/ Penicillin
- Other

Please list drug allergies:____

Is your child required by a physician to take a pre-medication (antibiotics) prior to dental treatment?
If yes, what condition____

Does your child have special health care needs? IF yes, please explain:____
____

Surgeries/ Hospitalizations / Other Medical Conditions:____
____

Please list all medications your child is currently taking:____
____

Please tell us anything you think we should know about your child's health of previous dental experiences that would help us treat your child or meet their needs____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/ Guardian Signature____Date________________________

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