For Office Use Only HYG Initials_______
Screening #s =
P / F / S = TEMP______
SDF =
Urgent = Teacher: _________
EO: 3_____14_____19_____30_____

2022-2023 DENTAL Consent Form

Community Health Center of Southeast Kansas will be providing dental treatment at your student'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__________________________________ **Grade:** _______ **Daytime Phone #**______________________

Student's LEGAL Name___________________________________ **DOB:** ____________**Gender:** _____ **Age:** _______

Parent/Guardian Name_____________________________________ **Parent/Guardian DOB:** ____________________

Address____**City**________________**State**________**Zip**__________

Student's Race

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

Student's Ethnicity (circle one) Hispanic or Latino OR Not Hispanic or Latino

DENTAL INSURANCE

Please complete the insurance section below. We will bill your insurance for services provided.

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

Commercial Insurance Policy Holder Name __________________________DOB__________ SSN#________________

Insurance Company________________________ Policy#________________________ Group#_________________

As parent or legal guardian of the patient named above, I give Community Health Center of Southeast Kansas permission to provide my child with dental services by CHC/SEK clinical professionals as is necessary in their judgement. I understand that no promise, guarantee, or warranty has been made regarding the result of any care provided by CHC/SEK. This dental treatment can include the following: **Cleaning, Sealants, Fluoride Treatment, Silver Diamine Fluoride Treatment, Temporary Fillings, Exam, Local Anesthesia, Primary Tooth Extractions.** This consent is valid for one year from the Parent/Guardian Signature date below.

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

____

Parent/Guardian Signature______________________________________ **Date**__________________________

PLEASE COMPLETE and SIGN SECOND PAGE

DENTAL HEALTH HISTORY FORM

Student's 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
- Asthma
- Diabetes
- Hepatitis
- Heart Disease
- Congenital Heart Disorder
- Artificial Heart Valve
- Other

Please list all DRUG, FOOD, and other ALLERGIES:

____

Name of child's medical doctor____

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________________

Community Health Center of Southeast Kansas/ 924 N Broadway/ Pittsburg, KS 66762/ 620-231-6788/ www.chcsek.org