For Office Use Only HYG Initials_______

Screening #s =

P / F / S = TEMP ________

SDF =

Urgent = Teacher ____________

EO:3______14______19______30______

2023-2024 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:** _______ **Parent/Guardian 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 student named above, I give Community Health Center of Southeast Kansas permission to provide 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. Dental services **MAY** include the following**: Cleaning, Sealant, Fluoride, Silver Diamine Fluoride, Temporary Filling, Injection of Local Anesthesia, Baby Tooth Removal, and Exam (exam for Head Start locations only).** This consent is valid for one year from the Parent/Guardian Signature date below. If local anesthesia is indicated and you would like a phone call before the injection, please check the box. ☐

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

____

Parent/Guardian Signature____ **Date**_____________________________

PLEASE COMPLETE and SIGN SECOND PAGE

DENTAL HEALTH HISTORY FORM

Student's First and Last Name____ DOB________________

When did your student last visit a dentist?

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

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

Does your student have special health care needs? If yes, please explain:

____

Surgeries/ Hospitalizations / Other Medical Conditions:

____

Please list all medications your student is currently taking:

____

Please tell us anything you think we should know about your student's health of previous dental experiences that would help us treat 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________________________