For Office Use Only
Screening #s =
P / F / S=
SDF=
Urgent=
EO: 3____14____19____30____

Dental Consent Form

Community Health Center of Southeast Kansas will be providing dental treatment 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 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, X-Rays, Local Anesthesia, Restorative Care (Fillings), Primary Tooth Extractions, Pulp Therapy, Stainless Steel Crowns, Space Maintainers and Administering Tylenol or Ibuprofen as needed**. 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 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
- ○ Asthma
- ○ Artificial Heart Valve
- ○ Diabetes
- ○ Hepatitis
- ○ Heart Disease
- ○ Congenital Heart Disorder
- ○ Other

Allergies:

- ○ Latex
- ○ Amoxicillin/ Penicillin
- ○ Other

Please list drug allergies:_____

Family Doctor (PCP)_____

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_____