

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian or<br>Alaskan Native | <input type="checkbox"/> White                     | <input type="checkbox"/> Native Hawaiian or Other<br>Pacific Islander |
| <input type="checkbox"/> Asian                                | <input type="checkbox"/> Black or African American | <input type="checkbox"/> 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.

This consent is valid for **one year** from the Parent/Guardian Signature date below.

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).**

☐ 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

### PAGE 2 of 2

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                      ☐ Pain                      ☐ Other  
☐ Cleaning                      ☐ Filling  
☐ Tooth pulled

**Medical History: Please check all that apply**

- ☐ Heart Murmur                      ☐ Congenital Heart Disorder  
☐ Artificial Joints/  
Pins/Screws                      ☐ Diabetes  
☐ Seizure Disorder                      ☐ Hepatitis  
☐ Asthma                      ☐ Heart Disease                      ☐ 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 \_\_\_\_\_