careArc

(Rev. 2-23)

DENTAL OUTREACH STUDENT CONSENT FORM

STUDENT INFORMATION				Chart Number:
Grade:	**Teacher:**	**School:**		
STUDENT'S Last Name:	**First Name:**			
Date of Birth:	**Age:**	**Gender:** ☐ Male ☐ Female		
Gender Identity:	**Sexual Orientation:**	**Phone Number:**		
Mailing Address:	**Apt. No.:**	**City:**	**State:**	**ZIP:**
Race: ☐ White ☐ Black/African-American ☐ More than 1 race ☐ Asian ☐ Other Pacific Islander ☐ American Indian/Alaska Native ☐ Native Hawaiian			**Ethnicity:** ☐ Latino/Hispanic ☐ Other	
PARENT/GUARDIAN Name:	**Relation to Student:**			
PARENT/GUARDIAN Social Security Number:	**PARENT/GUARDIAN Date of Birth:**			
Mailing Address:	**Apt. No.:**	**City:**	**State:**	**ZIP:**
Please mark the box next to each service you would like your child to receive: ☐ Sealants ☐ Cleaning ☐ Fluoride				

DENTAL INSURANCE INFORMATION (required): Fill out the following information about your CHILD: **(MUST BE COMPLETED IN FULL)**

By completing any portion of this form, you are authorizing CareArc to provide dental services for your child and to collect payment from KanCare and/or Private Dental Insurance. There is NO cost to the patient for this service.

Do you have Dental Insurance? ☐ YES ☐ NO

KanCare #: _____

☐ United Health Care ☐ Aetna ☐ Envolve (Sunflower)

☐ Private Dental Insurance - Name of Company: _____

ID#: _____ Group #: _____

Policy Holder Information (All information must be provided):

Last Name:	First Name:	Date of Birth:	Social Security Number:
Address:	City:	State:	ZIP:
Employer:	Relationship to Child:		
Parent/Guardian Signature:		**Date:**	

HEALTH HISTORY (required)

☐ Diabetes ☐ Anxiety/Depression ☐ Asthma ☐ Heart murmur ☐ ADD/ADHD ☐ Heart disease

☐ Autism ☐ Artifical heart valve ☐ Hepatitis ☐ Seizure disorder ☐ Congenital heart disorder

☐ Artificial joints/pins/screws ☐ Other _____

Known allergy to: ☐ Latex ☐ Amoxicillin/Penicillin ☐ Other _____

Please list all medications your child is currently taking:_____

_____

Does your child require a pre-medication (antibiotic) prior to dental treatment? ☐ Yes ☐ No

Name of child's dental home and date of last visit: _____ ____/____/____