Consent for Dental Screening and Fluoride

Healthy Smiles Community Dental Hygiene Program

Community Health Ministry

Our Dental Hygienists are knowledgeable and caring professionals that will provide your kids with an positive oral health experience. The dental hygienist will screen your child and your child will go home excited about brushing, flossing, and healthy snacks for their smile.

Name of Child_____ Date of Birth_____

Please check the appropriate box by each service you wish your child to receive.

YES	NO	
☐	☐	**Dental Screening**- Check for obvious signs of decay or other concerns.
☐	☐	**Fluoride Varnish**- A protective coating we paint on the teeth to make them strong. There is ***no charge*** for this important service, but if you have dental insurance we can bill on your behalf. (a very minimal reimbursement helps sustain our oral health educational programs) Insurance Name and #_____

I give permission for my child to receive the services checked above. I understand that these services do not replace a comprehensive evaluation by a dentist. If applicable, I consent to have KanCare, BCBS, and/or Delta Dental billed on my behalf and for Community Health Ministry, Inc. to receive all reimbursement. Non identifiable vital statistics such as oral condition, age, number of teeth, etc. may be gathered for state-wide research data only. No personal information will be shared. The Healthy Smiles Community Dental Hygiene Program will treat all patient information as protected health information (PHI) under HIPAA regulations.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____Date_____

Please share the following demographics to be used in aggregate only for state research: ***This information helps Community Health Ministry receive grants to continue providing free and reduced cost services for the community*

Gender ___M___F Race: ___ White___ Black___ Hispanic___ Asian___ Other

Family Monthly Income: _____ Income Source: (circle one) Full-time / Part-time / Social Security / Disability /Other

Family Size ____ City _____ State _____ County _____

RDH Use only: (Circle all that apply) D1206 D1330 D0190 D9999

Untreated: 0 1 Treated: 0 1 ECC: 0 1 White Spot lesions: 0 1

Deposits: 0 1 Gingivitis: 0 1 Sealants: 0 1 Treatment Urgency: 0 1 2

RDH Signature/Date: _____