**SECTION 1 – REGISTRATION**

**\*STUDENT INFORMATION:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Last Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Gender: □ Male □ Female

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher \_\_\_\_\_\_\_\_\_\_\_\_

**\*PLEASE CHECK ONE OPTION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  My child sees a dentist every 6 months.  |  |  |  My child DOES NOT see a dentist every 6 months.  |

**\*PLEASE CHECK WHAT SERVICES YOU WOULD LIKE YOUR CHILD TO HAVE:**

|  |  |
| --- | --- |
|  | Fluoride Varnish: a protective coating placed on teeth to make the enamel stronger (up to 3 per year). |
|  | Sealants: a plastic material placed in the deep grooves of permanent teeth to help prevent cavities. |
|  | Silver Diamine Fluoride (SDF): liquid applied to tooth that slows decay and turns decayed area black. |
|  | Dental cleaning: removal of plaque, calculus & debris by using hand instruments and polishing cup. (Service not allowed if your child sees a dentist every 6 months, please keep seeing your regular dentist for routine care!) |
|  | Temporary Filling: a temporary material placed in cavities to provide a short-term solution until a permanent filling can be placed. There is NO drilling. |
|  | Extraction of baby tooth: any VERY loose baby tooth that needs removed because of gross decay or heavy plaque.  |

**\*MY CHILD’S ETHNICITY IS**: □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic □ White □ Native Hawaiian/Pacific Islander □ Other

**\*PLEASE CHECK WHICH ONE APPLIES TO YOUR CHILD:**

\_\_\_\_\_\_ My child has no dental coverage.

\_\_\_\_\_ My child is covered under KanCare # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ My child has private dental insurance. (**Please fill out completely)**

Name on card holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card holder DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card holder SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # on back of card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*KPCHC is covering the cost of services but requires all available dental insurance information for billing purposes. You will NOT be responsible to pay any portion of these services, but if you have dental coverage, your insurance carrier will be billed. By signing below, you hereby authorize KPCHC to release the information requested by your insurance company necessary to process claims and authorize payment directly to KPCHC. Please check with your insurance company regarding coverage of fluoride applications if you choose to disclose this information. I confirm that the health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur. KPCHC staff will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by KPCHC and the facility/school who are responsible for medical treatment and/or record review. By signing below, I agree and understand.*

**\*PARENT/LAWFUL GUARDIAN INFORMATION:**

|  |  |
| --- | --- |
| Signature |  DOB: |
| Print First |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print Last |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |  |
| Daytime phone # |  DATE: |

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