Community Health Center of Southeast Kansas

Consent for In-School Dental Care

The Community Health Center of Southeast Kansas will be providing in-school dental care including screenings, sealants, fluoride, cleanings, exams, x-rays and fillings. There is no out-of-pocket cost to you for this service. However, insurance (if available) will be billed. **Please complete this form, front and back, sign and return to the school.**

Student Name_____ Date of Birth_____ Gender: ☐ Male ☐ Female

School Name_____ Teacher_____ Grade _____

Race/ Ethnicity (check all that apply)				
	☐ White	☐ Asian	☐ American Indian/Alaska Native	☐ Other
	☐ Black/African American	☐ Hispanic	☐ Native Hawaiian/Pacific Islander	

Parent/Guardian Information:

Name_____ Date of Birth _____

Address_____ City_____ State_____ Zip_____

Phone Number _____

☐ **KanCare (Amerigroup, United HealthCare, Sunflower) #** _____

☐ **Medicaid (Oklahoma or Missouri) #** _____ ☐ **No Insurance**

☐ **Private Dental Insurance (Please complete the following):**

Carrier _____ Policy # _____Group #_____

Policy Holder Name_____ Policy Holder DOB_____Policy Holder SSN_____

Mailing Address for Claims (found on back of card) _____

Phone Number for Claims_____

When did your child last visit a dentist? ☐In the past year ☐ More than a year ☐ Never

Name of dentist:_____

Please complete the back of this form →

Kansas Department of Health and Environment

Kansas Bureau of Oral Health

Medical History

Check all that apply:

☐ Artificial Heart Valve ☐Artificial Joints Pins/Screws ☐Asthma ☐Congenital Heart Disorder

☐Diabetes ☐Heart Disease ☐Hepatitis ☐Seizure disorder

☐Heart murmur ☐Autism

☐Other medical conditions or special health care needs: _____

_____

Any Known Allergies: ☐Latex ☐Amoxicillin/Penicillin ☐Other_____

Medications

Please list current medications:_____

_____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? ☐No ☐Yes

- If yes, for what condition_____

Other information

Please tell us anything we should know about previous dental experiences that would help us better treat your child:

_____

If there are services you would like to opt out of, please list them here:

_____

I am the parent or legal guardian/custodian and give my consent for the above named child to receive dental services provided by CHC/SEK. I confirm that the above health information is accurate to the best of my knowledge and I will contact CHC/SEK if any changes occur. I understand that all patient information is protected and will only be exchanged with staff employed by CHC/SEK and the school. I authorize CHC/SEK to release the information necessary to process insurance claims and authorize payment directly to CHC/SEK.

Parent/Guardian Signature_____ Date_____

If you have any questions, please contact the Dental Outreach Coordinator at **620-240-5657** or by email at **outreach@chcsek.org**