GraceMed
HEALTH CLINIC

Return by:
September 15th 2020

Consent for In-School Dental Care

(Español en el reverse)

*****If your child already sees a dentist regularly & you do not wish to switch, do not complete this form*****

Preventive services: GraceMed Health Clinic is providing in-school dental care including dental exams, x-rays as needed, cleanings, sealants, silver diamine fluoride and fluoride varnish. 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.

Restorative services (fillings & extractions of infected baby teeth): Not same day of preventive services. There is no out-of-pocket cost if you have KanCare/Medicaid or private insurance. All claims will be filed with your insurance. If uninsured, you must qualify for the free/reduced lunch program and an upfront cost of $60 per filling/extraction will apply on day of service.

Patient (Student) Information:

Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Phone#: _____ SSN # _____

Address: _____ City _____ Zip Code _____

School Name: _____ Grade 2020-2021 school year: _____

Race/Ethnicity: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific ☐ Caucasian/White ☐ More Than One Race ☐ Hispanic/Latino ☐ Not Hispanic/Latino

When did your child last visit the dentist? ☐ In the past 6 months ☐ In the past year ☐ More than a year ☐ Never

☐ Does your child qualify for free/reduced lunch program at school? ☐ Yes ☐ No

☐ KanCare # 001_____, ☐ No Insurance

☐ Private Dental Insurance Carrier _____ Policy#_____ Group #_ _____

Policy Holder Name_____ Policy Holder DOB _____ Policy Holder SSN_____

List any known allergies:

_____

_____

_____

Medical Conditions (check all that apply)

☐ Artificial Heart Valve ☐ Heart Murmur ☐ Congenital Heart Disorder ☐ Autism
☐ Heart Trouble/Disease ☐ Artificial Joint ☐ Hepatitis ☐ ADHD
☐ Asthma ☐ Diabetes ☐ Seizure Disorder

Other Medical conditions or special health care needs: _____

Please list all current medications: _____

Does your child require by a physician to take a pre-medication (antibiotics) prior to dental treatment? ☐ No ☐ Yes
If yes, for what condition? _____

I am the parent or legal guardian/custodian and give my consent for above named child to receive any dental treatment considered necessary by the dentist or hygienist for the prevention and treatment of dental disease. This includes exams, x-rays, cleanings, fluoride application, dental sealants, fillings, extraction of baby teeth and numbing of the mouth and teeth. This consent includes future dental visits, as some dental care requires multiple visits throughout the year. GraceMed will treat all patient information as protected health information under HIPAA regulations, exchanging the PHI only with personnel employed by them and the facility/school that are responsible for medical treatment and/or record review. **The above information is true to the best of my knowledge. If any change occurs during the year, I will contact GraceMed. This consent is in effect for one calendar year from the date of your signature.**

Parent/Guardian Signature_____ **Date** _____