CHC SEK School Health

For Office Use Only HYG Initials_____
Screening #s =
P / F / S = TEMP_____
SDF =
Urgent = Teacher: _____
EO: 3_____14_____19_____30_____

2022-2023 DENTAL Consent Form

Community Health Center of Southeast Kansas will be providing dental treatment at your student's school this year. 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.

School Name_____ **Grade:** _____ **Daytime Phone #**_____

Student's LEGAL Name_____ **DOB:** _____**Gender:** _____ **Age:** _____

Parent/Guardian Name_____ **Parent/Guardian DOB:** _____

Address_____**City**_____**State**_____**Zip**_____

Student's Race

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race

Student's Ethnicity (circle one) Hispanic or Latino OR Not Hispanic or Latino

DENTAL INSURANCE

Please complete the insurance section below. We will bill your insurance for services provided.

- ☐ KanCare (Aetna, United Health Care, Sunflower) #_____
- ☐ Medicaid (Oklahoma or Missouri)#_____
- ☐ No Insurance
- ☐ Commercial/ Private Insurance

Commercial Insurance Policy Holder Name _____DOB_____ SSN#_____

Insurance Company_____ Policy#_____ Group#_____

As parent or legal guardian of the patient named above, I give Community Health Center of Southeast Kansas permission to provide my child with dental services by CHC/SEK clinical professionals as is necessary in their judgement. I understand that no promise, guarantee, or warranty has been made regarding the result of any care provided by CHC/SEK. This dental treatment can include the following: **Cleaning, Sealants, Fluoride Treatment, Silver Diamine Fluoride Treatment, Temporary Fillings, Exam, Local Anesthesia, Primary Tooth Extractions.** This consent is valid for one year from the Parent/Guardian Signature date below.

Please list any services below you do **NOT** want your child to receive:

_____

Parent/Guardian Signature_____ **Date**_____

Kansas Bureau of Oral Health — Kansas Department of Health and Environment

PLEASE COMPLETE and SIGN SECOND PAGE

DENTAL HEALTH HISTORY FORM
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Student's Name_____ DOB_____

When did your child last visit a dentist?

- ○ In the past year
- ○ More than a year
- ○ Never

Why did your child visit the dentist?

- ○ Checkup
- ○ Cleaning
- ○ Pain
- ○ Filling
- ○ Tooth pulled
- ○ Other

Medical History: Please check all that apply

- ○ Heart Murmur
- ○ Artificial Joints/ Pins/Screws
- ○ Seizure Disorder
- ○ Asthma
- ○ Diabetes
- ○ Hepatitis
- ○ Heart Disease
- ○ Congenital Heart Disorder
- ○ Artificial Heart Valve
- ○ Other

Please list all DRUG, FOOD, and other ALLERGIES:

_____

Name of child's medical doctor_____

Is your child required by a physician to take a pre-medication (antibiotics) prior to dental treatment?
If yes, what condition_____

Does your child have special health care needs? If yes, please explain:

_____

Surgeries/ Hospitalizations / Other Medical Conditions:

_____

Please list all medications your child is currently taking:

_____

Please tell us anything you think we should know about your child's health of previous dental experiences that would help us treat your child or meet their needs_____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/ Guardian Signature_____Date_____