## Preventive Dental Program

## Patient Registration and Consent Form

**PLEASE PRINT (All items refer to the child for whom services are requested.)**

 **Please fill out this form today and return it to your child’s teacher.**

**YES NO I give permission for my child to have his/her teeth checked and to have sealants placed as needed.**

**YES NO I also give permission for my child to have his/her teeth cleaned.**

**YES NO I also give permission for my child to have fluoride applied to his/her teeth.**

 (IF NO, PLEASE COMPLETE CHILD’S NAME ONLY.)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

 CHILD’S NAME: Last First Middle SOCIAL SECURITY #

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 (MAILING) ADDRESS CITY COUNTY STATE ZIP CODE

4. \_\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BIRTHDATE SCHOOL GRADE/TEACHER

7. SEX (Check One) 8. RACE (Check one or more) ETHNICITY (Check One)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   | Female |  |  | W) White  |  | Y) Hispanic or Latino |
|   |  |  |  |  |  |  |
|  | Male |  |  | B) Black or African American |  | N) Not Hispanic or Latino |
|  |  |  |  |  |  |  |
|  |  |  |  | N) American Indian or Alaska Native |  |   |
|  |  |  |  |  |  |  |
|  |  |  |  | A) Asian |  |   |
|  |  |  |  |  |  |  |
|  |  |  |  | H) Native Hawaiian or Other Pacific Islander |  |   |

9. Parent/Guardian Contact Information: Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell/Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_

10. Child’s medical doctor :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Child’s dentist (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Does your child have any allergies to food or to medicine? Yes No If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. List any current medication your child takes (include over the counter medication or herbal medication) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Does your child have any illnesses, diseases, or conditions including ADHD, asthma, heart conditions, diabetes, contagious diseases? Yes No

 **Please explain:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Does your child have a Medicaid Card? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Applied/ Pending KCHIP**

 **We must have the number**  **Medicaid Card Number**

16. Does your child have other private or 3rd party Dental Insurance? Yes No (We do not file private insurance)

**17. Number of Persons in Household 18. Yearly Household Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Needed to determine charges for Non-Medicaid students - Strictly Confidential)**

 **\*\*\*\*PLEASE TURN FORM OVER\*\*\*\***

**CONSENT FOR HEALTH SERVICES: (Expires 1 year from date signed)**

Of my own free will I consent to care which may include screening, exams, treatment, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue.

This program does not take the place of regular check-ups at a dental office. The preventive dental services are being doing by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Dentist Board member for your county is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_who is supportive of the standards of practice of the public health hygienists and work with your Board of Health to develop and adopt protocols for these services.

This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA).

My signature below acknowledges my receipt of the health department’s ***“NOTICE OF PRIVACY PRACTICES”*** on the date stated

 **I understand that my child may be screened to check the retention of these sealants by the public health dental hygienist during the following school year.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *Signature of Parent/Guardian or other Authorized Person**Date Signature of Patient or Other Authorized Person Date*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please sign and date this section if you have Medicaid.**

**PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS**

ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to the local health department on my behalf, for services received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420.

**I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated above.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *Signature of Parent/Guardian or other Authorized Person**Date Signature of Patient or Other Authorized Person Date*

**Please mark which Managed Care Company you belong to with Medicaid):**

**\_\_\_\_\_\_\_\_ Avesis (Coventry Cares)**

**\_\_\_\_\_\_\_\_ Dentaquest (Wellcare)**

**\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return to your child’s classroom teacher or school nurse**