Douglas County Dental Clinic

# Friendly Smiles 2018-2019

# In-School Dental Program Consent Form

The Douglas County Dental Clinic's Friendly Smiles Program will be providing in-school dental care including sealants, fluoride, cleanings, exams, x-rays and fillings. **There is no out-of-pocket cost to you** for this service however, insurance (if applicable) will be billed. Your child is eligible if they have Kancare/Medicaid, qualify for the free/reduced lunch or have commercial insurance. If uninsured, you must qualify for the free/reduced lunch.

**IF YOUR CHILD HAS A DENTIST & YOU DO NOT WISH TO SWITCH, DO NOT COMPLETE THIS FORM**

**Patient (Child) Information:**

____________________ ____________________ ____________________

(Legal First Name) (Middle Name) (Last Name)

Date of Birth: ______________ Age: ________ SSN (last 4 digits): ________ Gender: ☐ male ☐ female

School Name: ______________________________ Grade school year 2018-2019: ____________

**Race/Ethnicity**: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Hispanic ☐ Other

## Parent/Guardian Information:

Parent Name: __________________________________ Date of Birth: ____________________

Parent Name: __________________________________ Date of Birth: ____________________

Primary Address: ______________________ City: _____________ State: ______ Zip: ________

Phone: ______________________________ Email: ____________________________________

☐ **Does your child qualify for the Free/Reduced Lunch Program at school?** ☐ **Yes** ☐ **No**

☐ **KanCare/Medicaid # 001 __________________,** **(circle provider) Amerigroup / United HealthCare / Sunflower**

☐ **No Dental Insurance**

☐ **Private Dental Insurance (must complete the following if there is private insurance):**

Carrier____________________________ Policy #____________________ Group #______________

Policy Holder Name_________________________________ Policy Holder DOB__________________

Policy Holder 9-digit SSN___________________________ Employer_____________________________

Mailing Address for claims (found on back of card) __________________________________________

Phone Number for Claims (found on back of card) ________________________________________

*****THIS IS A 2-SIDED FORM – Did you complete the other side? →**

2210 Yale Rd. Lawrence, KS 66049

Phone: 785-312-7770 ext. 206 / Fax: 785-312-9447

Website: www.dcdclinic.org ● Email: outreach@dcdclinic.org

## PATIENT (CHILD) MEDICAL HISTORY

**Check all that apply:** □ HIV / Aids □ Blood Disorder

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

□ Diabetes □ Heart Disease □ Hepatitis □ Seizure Disorder

□ Heart Murmur □ ADD/ADHD □ Autism □ Anemia

□ Other medical conditions or special health care needs: ________________________________________

____________________________________________________________________________________

**Any known allergies**: □ Latex □ Amoxicillin/Penicillin □ Other __________________________________

**Medications**
Please list all current medications: ________________________________________________________
____________________________________________________________________________________

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

Name of previous dentist: ______________________________________________________

You understand Douglas County Dental Clinic will be your child's dental care provider? ☐ **Yes** ☐ **No**
**(If you do not want us to be your child's dental provider, DO NOT COMPLETE this form)**

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

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

____________________________________________________________________________________

DCDC's dental outreach team will provide on-site dental care to your child while they are at school. If there are services (listed below) that you **do not wish** for us to perform, please indicate here: ______________________
____________________________________________________________________________________

I am the parent or legal guardian/custodian and give my consent for the 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 varnish, dental sealants, fillings, extractions of infected baby teeth, pulpotomies and numbing of mouth and teeth. This consent is good for the 2018-2019 school year as DCDC may provide in-school dental care on multiple dates throughout the school year. I understand that all patient information is protected and will only be exchanged with staff employed by the Douglas County Dental Clinic (DCDC) and the school. The above information is true to the best of my knowledge. If any changes occur during the school year, I will contact DCDC. I authorize DCDC to release the information necessary to process insurance claims and authorize payment directly to DCDC.

**Parent/Guardian Signature** ____________________________________ **Date** ________________

*****THIS IS A 2-SIDED FORM – Did you complete the other side? →**

2210 Yale Rd. Lawrence, KS 66049

Phone: 785-312-7770 ext. 206 / Fax: 785-312-9447

Website: www.dcdclinic.org ● Email: outreach@dcdclinic.org