Douglas County Dental Clinic

CONSENT FOR IN-SCHOOL DENTAL CARE

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 available) will be billed. **If your child already has a dentist you do not need to enroll in our program.**

PATIENT (CHILD) INFORMATION

Full Legal Name

Last Name	First	Middle

Date of Birth _____ Age _____ Gender: ☐ male ☐ female

School Name:_____ Grade school year 2017-2018:_____

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

Parent/Guardian Information:

Name_____ Date of Birth _____

Address_____ City_____ State_____ Zip_____

Phone _____ Email _____

□ **Does your child qualify for the Free/Reduced Lunch Program at school?** _____

□ **KanCare (circle one Amerigroup, United HealthCare, Sunflower) #**_____

□ **No Dental Insurance**

□ **Private Dental Insurance (please complete the following):**

Carrier_____ Policy #_____ Group #_____

Policy Holder Name_____ Policy Holder DOB_____

Policy Holder SSN_____ Employer_____

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

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

Have you completed 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? _____

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

Name of dentist: _____

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. 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** _____

Parent/Guardian Name (Printed) _____

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