FHC SMILES SCHOOL DENTAL OUTREACH PROGRAM
2020-2021 Consent Form

The Family Health Care (FHC) Smiles Program will be providing dental services in your child's school.

There will be no cost to you or the school for these services

FHC will bill Medicaid or KanCare for services. Your child is eligible if they have KanCare/Medicaid or qualify for free/reduced lunch. If your child has private dental insurance (ex: Delta), it is **NOT** necessary to participate in this program.

HIPAA Privacy Practice & Non-discrimination policies can be located on School or FHC Website.

School/Program Name: _____ Student Grade: _____ Teacher: _____
Child's Legal Name: _____ Date of Birth: _____ Male ____ Female ____
Medicaid/KanCare#: 001_____ Circle Provider: United Healthcare / Sunflower / Aetna
Eligible for FREE/Reduced Lunch Program: YES or NO Does your child have NO Dental Insurance _____
Child's Social Security #: _____
Parent/Guardian Name:_____
Address: _____ City: _____ Zip:_____
Phone #: _____ Alternate Phone #: _____
Race: (Please Circle all that apply) White Asian Hispanic American Indian/Alaska native
Native Hawaiian/Pacific Islander Black/African American
Ethnicity: (Please Circle all that apply) Non Hispanic/Latino Hispanic/Latino

HEALTH HISTORY

Does your child have a Dentist? YES or NO Name of Dentist: _____
When did your child LAST see a Dentist? (Circle one) 6 months 1 year more than 1 year Never
Does your child have any of the following:

___ Recent Dental Problems
___ Asthma or Wheezing
___ Behavioral Problems
___ ADHD/ADD
___ Autism/Spectrum Disorder
___ Diabetes
___ Heart Problems (Describe)
___ ANTIBIOTIC NEEDED PRIOR TO TREATMENT
____ Sickle Cell
____ Fainting/Seizures/Epilepsy
____ Liver Problems/Hepatitis
____ HIV/AIDS
____ Tuberculosis (TB)
____ Kidney Problems
____ Hemophilia/Bleeding Problems

LIST ALLERGIES: _____
_____
_____
LIST MEDICATIONS currently taking:
_____
_____
NAME of Physician and Pharmacy :
_____

OTHER Medical Conditions NOT listed:_____
_____

FHC Smiles 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 provide, please indicate here:
_____

The State of Kansas and the Dental Professionals providing this program are dedicated to improving your child's oral health by offering outreach dental services. After your child is treated you will receive a report stating what services were provided along with a dental referral if needed.

The individual's participation in this special event may be utilized anonymously for statistical purposes for the National Institute of Health and Information that identifies you will never be disclosed in any form or publication. You are consenting to a photograph for publicity purposes, which may include print television or web. Consent is given voluntarily and without compensation.

FREE **Our services include: Cleaning, Sealants, Fillings & Fluoride Treatment.**

I am the parent/guardian/custodian and give my consent for the above 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 treatment, dental sealants, fillings, extractions of infected baby teeth, pulpotomies and numbing of mouth and teeth. This consent is good for the 2019-2020 school years as FHC 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 Southwest Boulevard Family Health Clinic 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 FHC. I authorize FHC to release the information necessary to process insurance claims and authorize payment directly to FHC.

Parent/Guardian Signature: _____Date_____