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:

□ Artificial Heart Valve
□ Diabetes
□ Heart Murmur
□ HIV / Aids
□ Artificial Joints/Pins/Screws
□ Heart Disease
□ ADD/ADHD
□ Blood Disorder
□ Asthma
□ Hepatitis
□ Autism
□ Anemia
□ Seizure Disorder
□ Congenital Heart Disorder

□ Other medical conditions/special health care needs: _____

_____

Is your child required to take pre-medication (antibiotics) prior to dental treatment? ☐ **Yes** ☐ **No**
If yes, for what condition? _____

***Pre-med is prescribe for children with Cyanotic congenital heart disease, heart defect repaired with prosthetic material in the past 6 months, or a repaired congenital heart disease with residual defects.**

Medications
Please list all current medications: _____

_____

Any known allergies: □ Latex □ Amoxicillin/Penicillin □ Other _____

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)

Name of **previous** dentist: _____

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** _____

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