



Community Health Center of Southeast Kansas

Consent for In-School Dental Care

The Community Health Center of Southeast Kansas 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. Please select the services that you **DO WANT** your child to receive:

Preventative Services Include:

- Cleaning
- Fluoride
- Sealants

Restorative Services include all of these services:

- Filling, X-Rays, and Exam

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:
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Date of Birth _____

Gender: Male Female

School Name _____ Teacher _____ Grade _____

Race/Ethnicity (check all that apply)

- White
- Asian
- American Indian/Alaska Native
- Other
- Black/African American
- Hispanic
- Native Hawaiian/Pacific Islander

Parent/Guardian Information:

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number _____

KanCare (Amerigroup, United HealthCare, Sunflower) # _____

Medicaid (Oklahoma or Missouri) # _____ **No Insurance**

Private Dental Insurance (Please complete the following):

Carrier _____	Policy # _____	Group # _____
Policy Holder Name _____		
Policy Holder DOB _____		
Policy Holder SSN _____		
Mailing Address for Claims (found on back of card) _____		
Phone Number for Claims _____		

Medical History

Check all that apply:

- Artificial Heart Valve
- Artificial Joints Pins/Screws
- Asthma
- Congenital Heart Disorder
- Diabetes
- Heart Disease
- Hepatitis
- Seizure disorder
- Heart murmur
- Autism
- Other medical conditions or special health care needs: _____

Any Known Allergies: Latex Amoxicillin/Penicillin Other _____

Medications

Please list current medications: _____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment?

- No
- Yes

If yes, for what condition _____

Other information

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

Name of dentist: _____

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

I am the parent or legal guardian/custodian and give my consent for the above named child to receive dental services provided by CHC/SEK. I confirm that the above health information is accurate to the best of my knowledge and I will contact CHC/SEK if any changes occur. I understand that all patient information is protected and will only be exchanged with staff employed by CHC/SEK and the school. I authorize CHC/SEK to release the information necessary to process insurance claims and authorize payment directly to CHC/SEK.

Parent/Guardian Signature _____ **Date** _____

If you have any questions, please contact the Dental Outreach Coordinator at **620-240-5657** or by email at **outreach@chcsek.org**