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Dental Consent Form

Laura Gigstad, RDH, previously with Bright Smiles LLC, has joined the dental team at Heartland Community Health Center. Heartland will be providing dental services at your child's school this year. All children are invited to participate in the program, but the program is especially designed to provide dental services to children that are not receiving services elsewhere. *If your child already has a dental home, or have seen a dentist within the last year, please continue to see your dentist for regular cleanings and checkups!*

*** Please be sure to complete and sign the Medical History Form on the other side.**

School Name: _____

Student Name: _____ DOB: _____ Grade: _____ Gender: _____

Race: ___ American Indian or Alaskan Native ___ Asian ___ Native Hawaiian or Other Pacific Islander
 ___ Black or African American ___ White ___ Other Race

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino

Does the child have dental insurance? Yes No

If yes, complete the insurance section below. We will bill your insurance for services provided.

KanCare/Medicaid - Please circle one: Envolve Amerigroup United Health Care Comm. Plan

KanCare# _____ Title Number _____

Commercial/Private Insurance:

Subscriber Name _____ Subscriber DOB _____ Subscriber SSN# _____

Insurance Company _____ Policy # _____ Group # _____

Parent/Guardian name: _____ Daytime phone #: _____

Parent/Guardian Address: _____ City: _____ State _____ Zip: _____

Parent/Guardian Email Address: _____

Parent/Guardian Date of Birth: _____ Cell phone #: _____

Heartland offers medical, behavioral health, psychiatric, dental and physical therapy services to all, regardless of income or insurance status. Please check the box to receive more information, updates and reminders about Heartland programs, services and special events. We will not share your information with anyone. **YES**, I'd like more information about Heartland programs, services and special events.

As parent or legal guardian of the patient named above, I give Heartland Community Health Center permission to provide my child with dental sealants, fluoride treatment, silver diamine fluoride treatment, x-rays, and dental cleanings. I also acknowledge that the Privacy Practices were and are available for my review. This consent is valid for one year from the Parent/Guardian Signature date below.

I understand that all patient information is protected and will only be exchanged with staff employed/contracted by Heartland Community Health Center and, in certain circumstances, with the school (applicable only if your child's treatment occurs as part of a school-based program). I authorize Heartland to release the information necessary to process insurance claims and authorize payment directly to Heartland.

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Medical History Form

Student Name: _____ **DOB:** _____

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

Why did your child visit the dentist? Checkup Cleaning Mouth Pain Filling Tooth pulled Other

Medical History: Check all that apply

- Heart murmur Autism Asthma Diabetes Hepatitis Heart Disease
 Artificial Joints Pins/Screws Artificial Heart Valve Congenital Heart Disorder
 Seizure disorder Other _____

Any Known Allergies:

- Latex Amoxicillin/Penicillin Other _____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? No Yes

If yes, for what condition_

Does your child have special health care needs? No Yes

If yes, please explain: _____

Surgeries/Hospitalizations/Other Medical Conditions: _____

Medications your child is currently taking: _____

Other information- Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs.

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature: _____ Date: _____