School Dental Care Consent Form

West Central District Health Department (WCDHD) Tooth Tour mobile unit is taking dental care on the road to a school near you! Tooth Tour staff providers administering this program are dedicated to improving your child's dental health by offering outreach dental services. After your child is treated, you will receive a report by mail stating what services were provided. **Please select the preventive services that you DO WANT your child to receive:**

Preventive Services (please circle):

Cleaning Fluoride Sealants Silver diamine fluoride

PATIENT INFORMATION:

Last Name:	First:	Middle:

Date of Birth: _____ Gender: ❑ Female ❑ Male School Name: _____

Teacher: _____ Grade: _____

PARENT/GUARDIAN INFORMATION:

Name (Last, First): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Alternate Phone Number _____

Medicaid (MCNA)#_____

No Dental Insurance (self-pay) Cost of preventive services (*all fees must be paid prior to services*):

- **Child cleaning and fluoride (Ages 1-13): $55**
- **Sealants (if applicable): $30 per tooth**
- **Adult cleaning and fluoride (Ages 14 and up): $70**
- **Silver diamine fluoride (if applicable): $15 per tooth**

** Secured payment can be made at WCDHD's website under "Pay My Dental Bill" – www.wcdhd.org **
** If you are needing financial assistance, please contact WCDHD's Dental office to see if your child qualifies for assistance at 308-221-6829. **

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: _____

Please complete the back of this form

Medical History

Check all that apply:

❑ Artificial Heart Valve ❑ Artificial Joints/Pins/Screws ❑ Asthma ❑ Congenital Heart Disorder

❑ Diabetes ❑ Heart Disease/Heart Murmur ❑ Hepatitis ❑ Seizure Disorder

❑ Other medical conditions special needs: _____

_____

Any Known Allergies: ❑ Latex ❑ Amoxicillin/Penicillin ❑ Silver ❑ Other: _____

Please list all current medication: _____

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

If yes, for what condition? _____

Other Information:

When did your child last visit a dentist? ❑ Less than 6 months ago ❑ 6 months ago ❑ In the past year ❑ More than a year ago

❑ Never ❑ Unknown

Any additional information we should know about previous dental experiences that would help us better treat your child:

_____

CELLULAR PHONE, PHOTO, TEXT AND EMAIL CONTACT POLICY: By providing us with an email address or telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications - including but not limited to prerecorded or artificial voice message calls, text messages, emails and calls made by an automatic telephone dialing system - from us and our affiliates and agents at that number. This express consent applies to each such email and telephone number that you provide to us now or in the future and permits such calls, texts, and emails regardless of their purpose. Calls and messages may incur access fees from your cellular provider. From time to time West Central District Health Department takes photos or video of our programs to use in our marketing materials both in print and on the web. By signing this form, you're giving consent to have your photo used for these purposes. If you do not agree to have your photo used, please call West Central District Health Department and we will make arrangements to exclude your photo from use.

HIPAA: By signing this form, I understand the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and physician certifications and that my protected health information may be entered into state or national registries, access to which is restricted to persons who have signed agreements to keep all patient registry information confidential. I have been informed by you and your Notice of Privacy Practices containing a more complete description the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing below, I acknowledge: *The above information is true to the best of my knowledge. I have been educated on the public health dental hygiene scope of services and I have had a chance to ask questions and these have been answered to my satisfaction. I understand I will receive a visual dental exam by a public health dental hygienist with recommendation to have a complete exam by a dentist. I also understand the benefits and risks of public health dental hygiene and ask that services under the scope of a public health dental hygienist be performed to me or the person named below for who I am authorized to make this request. I am aware that if my insurance does not cover the care received I am financially responsible for the balance. Payment can be made by cash, credit card/debit card, check or Pay My Dental Bill @ www.wcdhd.org (WCDHD website).*

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

If you have any questions, please contact WCDHD Dental Department at 308-221-6829 or by email at dentalservices@wcdhd.org.

WEST CENTRAL DISTRICT HEALTH DEPARTMENT

ACCREDITED HEALTH DEPARTMENT · PHAB · PUBLIC HEALTH ACCREDITATION BOARD

Location: Groups/Dental/Forms
Original: 7/16/2018
Revised: 8/6/2018; 8/13/2018

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