NORTHERN KENTUCKY INDEPENDENT DISTRICT HEALTH DEPARTMENT

SCHOOL DENTAL PROGRAM

Consent Form and Patient Registration for 2016-2017

Patient Information: **PLEASE PRINT (All items refer to the child for whom you are consenting for dental services.)**
If NO dental services are wanted: Circle NO here and print name and grade/teacher only.

_____ _____ _____ _____-_____-_____
CHILD'S NAME: Last First Middle SOCIAL SECURITY #

_____ _____ _____ _____ _____
(MAILING) ADDRESS CITY COUNTY STATE ZIP CODE

_____/_____/_____ _____ _____
BIRTHDATE SCHOOL **GRADE/TEACHER**

PARENT/GUARDIAN NAME: _____ RELATIONSHIP TO CHILD:_____

_____ OR _____ EMAIL _____
PARENT/GUARDIAN PHONE

No or Very Low Cost Dental Services Available; see attached letter for explanation of any charges:
Preschool children receive a dental screening and fluoride varnish
All other grades receive dental sealants if needed, dental cleaning, dental screening, and fluoride varnish

ALL MUST SIGN - FOR CONSENT FOR DENTAL SERVICES

MUST BE SIGNED FOR CHILD TO BE SEEN!

Of my own free will I consent to dental care which may include dental screening, fluoride, cleaning, and sealants given to minor child by Public Health Dental Hygienists staff or agents of this health department. NKHD Public Health Registered Nurses may provide dental screening and fluoride only. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue. This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA). My signature below acknowledges my receipt of Northern Kentucky Independent District Health Department's newly revised ***"NOTICE OF PRIVACY PRACTICES***" which is available on www.nkyhealth.org or at your school's office.
I understand that no dentist is present for the dental procedures, and the public health dental hygienists are working under the supervision of the N.KY Board of Health, board member Jack Lenihan DMD, and Jonathon Rich DMD. These services do not take the place of regular dentist visits, and all children will be referred to their own dentist for a full exam. I also understand that my child might receive fluoride 2 times during the school year and may be checked for the retention of any sealants placed during the following school year.

_____ _____
Signature of Parent/Guardian or other Authorized Person ***Date***
(Expires 1 year from date signed)

ADDITIONAL SIGNATURE IF CHILD HAS MEDICAID

ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to Northern Kentucky Health Department on my behalf, for services I received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420. **I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated.**

_____ _____
Signature of Parent/Guardian or other Authorized Person of child with Medicaid ***Date***

10 DIGIT MEDICAID NUMBER (WE MUST HAVE NUMBER): __ __ __ __ __ __ __ __ __ __

Circle your Medicaid type if known: AETNA WELLCARE PASSPORT HUMANA ANTHEM

**** TURN FORM OVER AND COMPLETE ****

NORTHERN KENTUCKY INDEPENDENT DISTRICT HEALTH DEPARTMENT

ALL MUST FILL OUT - MEDICAL INFORMATION:

Child's medical doctor: _____ Phone number:_____

Child's dentist: _____ Date of last dental exam: _____

Does your child have any allergies to food or to medicine? ☐Yes ☐ No If yes, please list_____

List ANY medication your child takes (include over the counter medication or herbal medication) _____

_____

Does your child have ANY illnesses, diseases, or conditions including ADHD, asthma, heart conditions, diabetes, contagious diseases? Yes No

Please explain:

_____

DEMOGRAPHICS:

SEX (Check One)
- ☐ Female
- ☐ Male

RACE (Check one or more)
- ☐ W) White
- ☐ B) Black or African American
- ☐ N) American Indian or Alaska Native
- ☐ A) Asian
- ☐ H) Native Hawaiian or Other Pacific Islander

ETHNICITY (Check One)
- ☐ Y) Hispanic or Latino
- ☐ N) Not Hispanic or Latino

Complete this section if child does NOT HAVE Medicaid:

Does your child have private Dental Insurance? Yes No

We do not accept private dental insurance but will be happy to see your child at our low fees based on a sliding scale.

Number of Persons in Household _____ Yearly Household Income $_____

(This Information needed to determine charges for Non-Medicaid students - Strictly Confidential)

Please return form to your child's classroom teacher or school nurse

Contact Linda Poynter at 859.363.2035 or linda.poynter@nkyhealth.org with any questions. The Northern Kentucky Health Department has been providing dental services in our schools for over 10 years.