NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT

# SCHOOL DENTAL PROGRAM

## Consent Form and Patient Registration

**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: _____

HOME PHONE _____ OR CELL PHONE - TEXT? Y or N _____ EMAIL _____

No or Very Low Cost Dental Services Available; see attached letter for explanation of any charges:
Students receive a dental screening, fluoride varnish, and a dental cleaning.
Dental sealants are applied on permanent molars for those who need them (usually over age 6).
This program is not a replacement for your regular dentist.

## 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 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: AETNA WELLCARE PASSPORT HUMANA ANTHEM

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

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**CHILD NAME** _____ **BIRTHDATE**_____

## ALL MUST FILL OUT - MEDICAL INFORMATION:

Child's medical doctor: _____ Phone number:_____

Child's dentist: _____ Date of any scheduled dental appointments _____

Date of last dental visit (circle): NEVER LESS THAN 6 MONTHS MORE THAN 6 MONTHS

Does your child have any allergies to food or to medicine (circle)? Yes No If yes, 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:**

_____

## ALL MUST FILL OUT - 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

## ALL MUST FILL OUT – FINANCIALS:

| | | |
|---|---|---|
| Is your child currently covered by Medicaid? | Yes | No |
| Is your child currently covered by private Dental Insurance? | Yes | No |
| Is your child enrolled in KTAP? | Yes | No |
| Is your child enrolled in the Food Stamp Program (SNAP)? | Yes | No |

**We do not accept private dental insurance but can 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 - Strictly Confidential)**

**Please return form to your child's classroom teacher, school nurse or family resource person.**
Contact Linda Poynter at 859-363-2035 or linda.poynter@nkyhealth.org with any questions.
NKY Health has been providing dental services in our schools for 14 years.