NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT

SCHOOL DENTAL PROGRAM

Consent Form and Patient Registration

No Cost Dental Services Available

Students receive a dental assessment, 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 and is ideal for children who have not seen a dentist in the last six months.

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 _____ _____
HOME PHONE CELL PHONE EMAIL

CONSENT FOR DENTAL SERVICES - YOU MUST SIGN FOR YOUR 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 my child by NKY Health dental hygienists or agents of this health department. NKY 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 my child. I also understand my child 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 child's 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 Health Department's ***"NOTICE OF PRIVACY PRACTICES"*** which is available on www.nkyhealth.org or at the 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. 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)

IF YOUR CHILD HAS MEDICAID – ADDITIONAL SIGNATURE NEEDED!

ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to Northern Kentucky Health Department on my behalf for services my child received. I also authorize the local health department to release medical information about my child 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 ***Date***

If your child is enrolled in Medicaid, it is your responsibility to provide a Medicaid number. We must file Medicaid for payment.

10 DIGIT MEDICAID NUMBER ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Circle your Medicaid type: AETNA WELLCARE PASSPORT HUMANA ANTHEM MOLINA UHC

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

CHILD'S NAME _____ **BIRTHDATE**_____

MEDICAL INFORMATION - ALL MUST BE FILLED OUT:

Child's medical doctor: _____ Phone number:_____

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

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

Does your child have any allergies to food or 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, conditions including ADHD, asthma, heart conditions, diabetes or contagious diseases? Yes No
Please explain:

_____

Has your child tested positive for COVID-19? Yes No If Yes, date:_____

DEMOGRAPHICS - ALL MUST BE FILLED OUT:

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

FINANCIALS - : ALL MUST BE FILLED OUT:

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

Number of Persons in Household _____ Yearly Household Income $_____

Medicaid – If your child is enrolled and eligible for Medicaid, it is your responsibility to provide a Medicaid number. We must file Medicaid for payment.

No Medicaid – Services will be provided to your child at no cost to you **IF** it has been at least **6 months** since their last dental visit.

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.