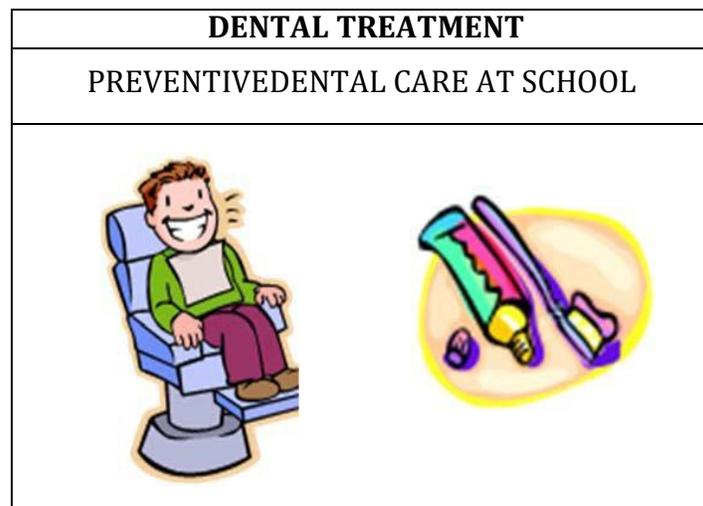




DENTAL OUTREACH PROGRAM Consent Packet

Dear Parent/Guardian:

Cumberland Family Medical Center Inc., in conjunction with Healthy Kids Clinic and the Family Resource/Youth Services Center, is offering dental preventive treatment at your child's school! These appointments will be performed by a licensed dentist and may occur once or twice during the school year. This preventive service includes an exam, cleaning, fluoride treatment, x-rays, and sealants, if needed. If any dental issues are found, the child will be referred to his/her personal dentist. A follow-up report will be provided to the parent/ guardian. Each participating student will receive a gift pack that includes a toothbrush and toothpaste. If you would like for your child to participate, please complete both forms and return them to your child's school.



**YOU MUST SIGN THE FORMS IN THIS PACKET
if you want your child to receive dental services!**

*If your child sees a dentist on a regular basis for routine care,
you do not need to sign up for this program.*



FAMILY DENTAL OF KENTUCKY

A Part of Cumberland Family Medical Center, Inc.

Permission for Dental Treatment

School: _____

Grade: _____

Teacher: _____

I understand that Cumberland Family Medical Center, Inc. shall provide a copy of its Notice of Privacy Practices upon my request, which is also available at www.cumberlandfamilymedical.com. By signing this form, I give consent for my child's dental insurance to be billed.

Student Information (Please Print):

Name: _____ Date of Birth: ____/____/____
First Middle Last

Address: _____

Gender: Male / Female Street Social Security Number (Required): _____ City, State Zip Code

Race: White Black or African American Asian Native American or Alaska Native

Ethnicity: Hispanic or Latino Not Hispanic or Latino Native Hawaiian or Pacific Islander

Language: English Spanish Other:

Parent/Guardian Information (Please Print):

Name: _____
First Middle Last

Relationship to Child: _____ Daytime Phone: _____ Emergency Phone: _____

Number of People in Household: _____ Annual Household Income: _____

Insurance Information (Please Print):

Dental Insurance Company: _____ ID Number: _____

Whose name is on the policy? _____

Policy Holder Date of Birth: ____/____/____

Medical History Information:

Has the student been to the dentist before? YES / NO If yes, date of last visit? _____ Name of student's dentist: _____

Is there anything else we should know about the **student's health or about any dental care** he/she has had in the past? If so, please explain:

Please mark the following boxes to give consent for services:

- Yes.** I give consent for the named student to have a dental **exam**, prophylaxis (**dental cleaning**), and **fluoride treatment**. I understand this student may receive these services twice during the school year. I give permission for insurance to be billed if applicable. I understand it is my responsibility to notify Cumberland Family Medical Center, Inc. regarding any restrictions to disclosure of my health information regarding this or any subsequent visit. I also give consent for the named student's exam results to be shared with their local dental home.
- Yes.** I give consent for the named student to receive **dental x-rays** if deemed necessary by the dentist. I also give consent for the named student's x-rays to be shared with his/her local dental home.
- Yes.** I give consent for the named student to receive **dental sealants** on permanent molars if deemed necessary by the dentist. I also give consent for an Avesis dental consultant to perform sealant rechecks up to one year after the sealant is placed.

By initialing here, I am choosing NOT to consent to dental treatment for my child because my child visits a local dentist regularly. _____

Parent/Guardian Signature _____ Print Name _____ Date _____

Patient Name: _____ Birthday: _____

DENTAL / HEALTH HISTORY

HEALTH HISTORY: (Please circle your answers.)

Circle if your child NOW has or has EVER had any of the following health problems:		
Yes	No	Rheumatic Fever/Mitral Valve Prolapse/Heart Problems If so, is child supposed to take antibiotics before dental care? Yes - No - Don't Know
YES	NO	My child is ALLERGIC to MEDICINES (like antibiotics): Please LIST the medicines your child is allergic to here: _____
Yes	No	Diabetes
Yes	No	Epilepsy/Seizures
Yes	No	Asthma
Yes	No	Sensory Impairment
YES	NO	My child takes MEDICINE every day for a health condition. Please LIST the medicines your child takes each day here: _____
Please list any other medical or behavioral health conditions that may affect treatment:		

DENTAL HISTORY: (Please circle your answers.)

How long has it been since your child VISITED a dentist?	NEVER	1 year	2 years
Does your child have a DENTAL HOME? (A dentist your child visits every 6 months.)		No	Yes
*If so, which dental office is your child's dental home?			
*What was the main reason for your child's last dental visit?			
In the past 6 months, did your child have a TOOTHACHE?	Yes		No
Has your child ever needed dental care but could NOT get it?		Yes	No
*What was the main reason your child could not get care?			
Describe the condition of this CHILD'S TEETH:	Poor	Fair	Good
Describe the condition of the PARENT'S TEETH: Dentures	Poor	Good/Fair	Excellent

Based on the answers you give here and the results of the dental exam at school, we will determine your child's caries risk category.	HIGH Risk	MEDIUM Risk	LOW Risk
Child has several sugary snacks/drinks between meals	A lot, all day	Sometimes	Only at mealtime
Child has had fillings or visible cavities	Yes		No
Child has special health care needs that make it hard to brush (developmental, mental, physical disabilities)	Yes (age 0-14)	Yes (over age 14)	No
Child has had chemo or radiation	Yes		No
Child has had eating disorders		Yes	No
Child has plaque on teeth		Yes	No
Child takes medications that cause dry mouth		Yes	No
Child drinks city water (has fluoride), brushes daily with toothpaste, or has fluoride applied by dentist every 6 months		No	Yes