FAMILY
MEDICAL CENTERS

HEALTHY
KIDS CLINIC

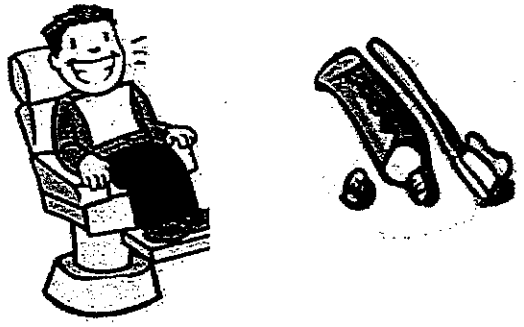
FAMILY DENTAL
OF KENTUCKY
A Pod of Cumberland Family Medical Center, Inc.

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 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.

DENTAL TREATMENT
PREVENTIVEDENTAL CARE AT SCHOOL


<u>YOU MUST SIGN THE FORMS IN THIS PACKET</u>
<u>if you want your child to receive dental services!</u>

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: _____
Street City, State Zip Code

Gender: Male / Female Social Security Number (Required): _____

Race: ☐ White ☐ Black or African American ☐ Asian Native American or Alaska Native ☐ Native Hawaiian or Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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*

Informed Consent for Preventive Dental Care

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**