FAMILY MEDICAL CENTERS

HEALTHY KIDS CLINIC

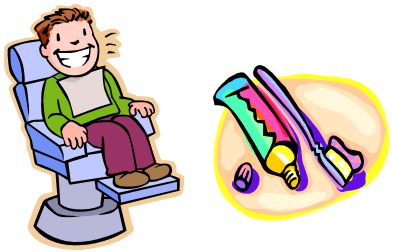
FAMILY DENTAL OF KENTUCKY
A Part of Cumberland Family Medical Center, Inc.

DENTAL OUTREACH PROGRAM

Consent Packet

Dear Parent/Guardian:

Cumberland Family Medical Center, in conjunction with your child's Family Resource/Youth Services Center, is offering dental preventative treatment at your child's school! These appointments will be performed by a licensed dentist and may occur twice during the school year. This preventative service includes an exam, cleaning, fluoride treatment, x-rays, and sealants, if needed. If any dental issues are found, the child may be referred to his/her personal dentist and 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 the applicable forms and return them to your child's school. If you would like for your child to also participate in a program that would allow them to receive restorative dental treatment during the school day through the Elgin program, please read and fill out the appropriate form in this packet.

DENTAL TREATMENT		**TRANSPORT SERVICE**
PREVENTIVE DENTAL CARE AT SCHOOL		BUS RIDE TO FAMILY DENTAL OF KENTUCKY IN WHITLEY CITY FOR FILLINGS, CROWNS, ETC.
		 (1st through 6th graders only)

<u>YOU MUST SIGN THE FORMS IN THIS PACKET</u>
<u>if you want your child to receive dental services!</u>
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
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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? _____ Address (if different from above):_____

Policy Holder Date of Birth: ___/___/___ Insurance ID # or Policy Holder Social Security #:_____

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**

PERMISSION TO TRANSPORT BY BUS FOR DENTAL TREATMENT

McCreary County Public Schools along with the Family Dental of Kentucky Mobile Dental Team have agreed to work together for the benefit of the children in our community. McCreary County Public Schools are providing supervised transportation from your child's school to the local Family Dental of Kentucky dental office in Whitley City, KY. The children will ride aboard a supervised county school bus. If your child is participating in the program, you will be contacted before the child's scheduled dental visit to obtain any necessary information that may be required and answer any questions you may have.

I give permission for my child, _____, to be transported by a bus provided by the McCreary County Public School System. I understand my child will be taken from the school to the dental office and brought back after his/her dental treatment.

_____ _____

SIGNATURE of Parent or Guardian **Date**

PERMISSION FOR DENTAL TREATMENT

McCreary County Public Schools and the Family Dental of Kentucky Mobile Team would like to render dental services to your child. Our goal is to help your child achieve good oral health and empower them with the knowledge to maintain and sustain it. Your child is in need of some basic dental care, which may include the following procedures:

Dental Exam and Prophy (Cleaning), Dental x-rays, Dental Anesthetic, Dental Sealants
Treatment of decayed or broken teeth with fillings or crowns
Treatment of infected teeth or gums
Simple extractions of baby teeth if needed

Because your child is a minor it is necessary to have your signed permission. Your signature affixed below authorizes examination and treatment as necessary and the use of procedures the dentist may deem necessary during the performance of his services.

I give permission for my child, _____, to receive dental treatment. I do hereby request and authorize the dentist and dental staff to perform necessary dental services for my child, and any services deemed advisable by the dentist, even if I am not present during dental treatment. Please call the school if you would like to be present for your child's dental treatment appointment. The dental clinic will attempt to call the numbers you provide below on the day of treatment to discuss the plan with you.

_____ _____

SIGNATURE of Parent or Guardian **Date**

_____

Name of Parent or Guardian (please print)

If you have any questions, please call the Family Resource Center at your child's school.