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, 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.

| **DENTAL TREATMENT** |
| --- |
| PREVENTIVE DENTAL CARE AT SCHOOL |
|   |

**<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.*

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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. I understand that these services are subject to my insurance plan's limitations and maximums.*

**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:

**Insurance Information (Please Print):**

Dental Insurance Company:_____ ID Number: _____

Whose name is on the policy? _____

Policy Holder Date of Birth: ____/____/____

**Parent/Guardian Information (Please Print):**

Name: _____
*First Middle Last*

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

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

**Medical History Information:**

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

Does the student have a future appointment scheduled with a dental office? YES / NO

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<br>If yes, please Explain: _____ |
| **Yes** | **No** | Is child supposed to take antibiotics before dental care?<br>If yes, please explain: _____ |
| **Yes** | **No** | **My child is ALLERGIC to MEDICINES (like antibiotics):**<br>**Please LIST the medicines your child is allergic to here: _____** |
| **Yes** | **No** | **My child is allergic to something other than a medicine. Please list your child's other allergies 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.**<br>**Please LIST the medicines your child takes each day here: _____**<br>**_____** |
| **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?<br>(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** |