SALINA FAMILY HEALTHCARE CENTER

Dental

Phone 785-826-9017

Fax 785-826-9161

CONSENT FOR FLUORIDE VARNISH APPLICATION

Student's Name ______________________________ Student's Birthdate _______________

Parent/Guardian Name ________________________ Parent/Guardian Phone # ___________

Parent/Guardian Address ____

Student's School _________________________ Gender of Student ___________________

Student's Teacher _______________________ Student's Grade Level ________________

Race:
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic
- ☐ Native American
- ☐ White/Caucasian

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other ____________________

As the parent or legal guardian of the above child, I understand that fluoride varnish is an effective way to improve your child's oral health in an effort to prevent painful cavities, expensive dental care and school absences. I give permission for my child to receive a fluoride varnish application.

**If your child has a pine allergy it is possible for them to have an allergic reaction to the fluoride varnish.

Salina Family Healthcare Center is covering the cost of services, but does require all available insurance coverage information for billing purposes. I will NOT be responsible to pay any portion of these services. **Salina Family Healthcare Center will bill my insurance provider for the services.** I hereby authorize Salina Family Healthcare Center to release the information requested by the insurance program necessary to process claims and authorize payment directly to Salina Family Healthcare Center Dental Clinic.

_____My child is covered under KanCare # _________________ or SSN_________________

_____My child has no dental coverage.

_____My child has dental insurance from a private company.

For Private Dental Insurance:

Policy Holder's Name: ______________________________ Date of Birth: __________

Insurance Company: ______________________________ Phone Number: __________

Insurance Co. Address: ____

Group ID Number: ______________________ Member ID Number: ________________

Parent/Legal Guardian Signature: ________________________________ Date ________

Screened By:_______

Fluoride Applied By:_______

Date Performed:___________