Health Partners of Western Ohio

Dental Outreach Consent Form

PLEASE SIGN AND RETURN TO SCHOOL

Our Outreach Team will be coming to your school and offering dental services. Regular dental check-ups are an important part of overall health. **We will bill Medicaid and Private Insurance.** The dental visit will be considered a preventive visit through your insurance company. If your child has no health coverage there will be NO charge. Our center can help sign you and your family up for insurance, if eligible. The program is open to all children.

Please check Yes or No and complete the form below:

☐ **YES,** I give my informed consent for my child to participate in the School-Based Dental Outreach Program. Please complete the rest of this form, **PRINT & SIGN at the bottom** and return it to your child's school.

☐ **NO,** I do not want my child to receive dental services.

Child's First Name: _____ Child's Last Name: _____

Child's Date of Birth: _____/_____/_____ ☐Female ☐Male Child's SSN: _____-_____-_____

School Name: _____ Grade _____ Rm # _____ Teacher: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____ County: _____

Race/Ethnicity (Circle all that apply): White Black/African American Hispanic Asian Pacific Islander/ Hawaiian Native American/Alaskan Native Other

Does your child have any serious health problems? ☐Yes ☐ No If YES, please explain: _____

Does your child have any allergies? (i.e.: acrylics/plastics/bees/latex, etc.) ☐Yes ☐ No Please List: _____

Insurance Information

Medicaid Plans

Circle plan your child has and fill in Billing Information

Humana | buckeye health plan | CareSource | UnitedHealthcare | MOLINA HEALTHCARE | Anthem | AmeriHealth Caritas | Other Medicaid

Member ID # _____

Medicaid # (MMIS) _____

Private Insurance Plans

If your child has private insurance please fill in Billing Information

Name of **Dental** Plan: _____

ID # _____

Group # _____

Insurance Holder Name: _____

Insurance Holder DOB: _____

Insurance Holder SSN: _____

Claim Address: _____

Phone # _____

Employer: _____

I have read and completed the information on this consent form and my signature below gives consent for treatment and is valid for the life of the student. I have read and understand the Notice of Privacy Practices on the back of this form and know that a copy is available from the school office or hpwohio.org. This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to the Health Insurance Portability and Accountability Act. I authorize Health Partners staff to provide dental at school to the above named child. The dental services include an exam, cleaning, fluoride, sealants, and the application of Silver Diamine Fluoride as needed. (The use of Silver Diamine Fluoride may discolor any cavities to a brown or black color. SEE BACK FOR DETAILS.) I give consent for Health Partners staff to collaborate with school staff especially when additional dental and/or vision treatment is necessary to ensure my student receives follow-up care.

Parent/Guardian Signature _____ Date _____

Print Parent/Guardian Name _____

To find a medical or dental office near you, please visit our website at www.hpwohio.org or call 567-825-0226. Like us on Facebook!

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