# School-based Dental Consent Form

Scan to learn more about our program and to complete this form online!

| Student's School | Student's Teacher | Student's Grade |
|---|---|---|
| | | |

**Dear Parent/Guardian**:
Community Health Center of Snohomish County's Dental team will be offering Smile Checks (dental screenings), and/or sealants and fluoride at your student's school at no cost to you. A dentist will examine your student's teeth and determine which teeth need to be sealed. Sealants and fluoride help prevent cavities and are recommended by the American Dental Association. Please fully complete and sign this form so we can provide high-quality healthcare services for your student. If you have more than one student, please complete one form per child. Your school will announce upcoming dates when we will be onsite. **This consent will remain active for the school year unless expressly revoked in writing.**

| Student's Last Name | Legal First Name | MI |
|---|---|---|
| | | |

| Date of Birth MM/DD/YYYY / / | Age | Gender ☐ Male ☐ Female ☐ Other: |
|---|---|---|
| | | |

| Address | City | Zip Code |
|---|---|---|
| | | |

**Consent to complete:** Check the "Yes" box for treatments you are giving permission for, and the "No" box for those that you do NOT give permission for. **Smile Checks (visual screening) will be performed in the Fall and Spring and are required to receive sealants or fluoride**. Sealants will be provided based on patient age and findings of the screening.

| | | |
|---|---|---|
| Smile Check *Required for services below* | ☐ Yes | ☐ No |
| Sealants | ☐ Yes | ☐ No |
| Fluoride Varnish | ☐ Yes | ☐ No |

**Please provide the following information**

<u>All students are eligible. Service is provided at no cost to your family.</u> Insurance will be billed when applicable, but no student or family will be charged for services or receive a bill.

☐ Washington Apple Health: Please list your student's **Provider One number:**_____

☐ Private dental insurance* (Ex: Delta, BlueCross):

| ID# | | Group # | |
|---|---|---|---|
| Subscriber Name | | Subscriber Date of Birth | |

**Any charges may be applied towards annual benefit limits*

☐ Uninsured ☐ I would like a CHC staff member to reach out to me about insurance enrollment support

**By my signature, I am giving CHC of Snohomish County permission for my student to receive a Smile Check (Dental Screening) and the marked treatment(s) above:**

| Parent/Guardian – Print Name | Phone Number ( ) --- |
|---|---|
| Parent/Guardian – Signature | Today's Date MM/DD/YYYY / / |

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have rights to privacy regarding my protected health information (dental & health records). I understand CHC of Snohomish County may contact me about appointment reminders, treatment options, test results or other health related benefits and services via phone call, text message, email, or voicemail. I hereby acknowledge I have access to CHC's

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**Notice of Privacy Practices before signing the consent at any time by contacting: Community Health Center of Snohomish County, 8609 Evergreen Way, Everett, WA 98208, or phone (425) 789-3700 or by going to our website at: www.chcsno.org.**

To provide the best care possible, we also ask for demographic information. You have the right to refuse to answer these questions. Your answers will not be shared or used for any purpose other than gathering general demographics information to best serve our patients and community.

| | | |
|---|---|---|
| What is your race or family background? | ❑ American Indian or Alaska Native<br>❑ Asian Indian<br>❑ Black or African American<br>❑ Chinese<br>❑ Declined to specify<br>❑ Filipino<br>❑ Guamanian or Chamorro<br>❑ Japanese | ❑ Korean<br>❑ More than one race<br>❑ Native Hawaiian<br>❑ Other Asian<br>❑ Other Pacific Islander<br>❑ Other Race<br>❑ Samoan<br>❑ Vietnamese<br>❑ White |
| What is your ethnicity? | ❑ Chicano/a<br>❑ Cuban<br>❑ Declined to specify<br>❑ Hispanic, Latino/a, or Spanish Origin<br>❑ Hispanic, Latino/a, or Spanish Origin Combined | ❑ Mexican<br>❑ Mexican American<br>❑ Not Hispanic, Latino/a, or Spanish Origin<br>❑ Other<br>❑ Puerto Rican<br>❑ Unknown |
| What is your student's preferred language? | ☐ English<br>☐ Spanish<br>☐ Russian<br>☐ Arabic | ☐ Ukrainian<br>☐ Vietnamese<br>☐ Other: _____ |
| Do you or your student need an interpreter? Interpretation is provided at no cost by CHC. | **Student**<br>☐ Yes ☐ No | Language: _____ |
| | **Parent/Guardian**<br>☐ Yes ☐ No | Language: _____ |
| What is your housing status? | ❑ I rent or own a home, apartment, condo, etc. or am sharing a residence by choice<br>❑ I am staying with friends and/or family temporarily because I cannot afford or find affordable housing<br>❑ I am staying in a motel/hotel or transitional housing facility<br>❑ I am living in a shelter<br>❑ I am living outside or in my car<br>❑ I have permanent housing that includes supportive services for people exiting homelessness | |
| At any point in the past two years, has seasonal or migrant farm work been your or your family's main source of income? | ❑ Yes, Seasonal<br>❑ Yes, Migratory<br>❑ No/Neither | |
| What is your household's monthly income? $ | Total number in household: | |