Purchase District Health Department
Promoting Health. Preventing Disease. Protecting You.

floss & gloss

Dental Cleaning and Sealant Program

Children's Access to Oral Health West Kentucky

270-444-9625 ext 103

Leah Smothers, PHRDH, Mandy Sizemore, PHRDH, Jenny Moore, Dental Assistant

CONSENT FOR DENTAL TREATMENT

School:	Teacher:	Grade:
Name:	Birthdate:	**Social Security Number REQUIRED**:
Address:		
Race:	Hispanic: Y N	Gender: M F
Legal Guardian:	Phone:	Phone:
# in Household:	Annual Income:	

Circle one: No Insurance Private Insurance Medicaid (Medicaid will be billed for any child who has Medicaid. We do not bill private insurance or no insurance patients.)

Dental History

Dentist:	Last visit:	See dentist every 6 months: Y N

Medical History

Has your child ever had any of the following (if yes, please explain):

◯ Surgery	◯ Diabetes	◯ Hearing loss
◯ Bleeding Problems	◯ Heart Murmur	◯ Heart Problems
◯ Seizures/Epilepsy	◯ Autism	◯ ADD/ADHD
◯ Cancer/Chemo	◯ OTHER:	◯ Asthma

Explain:
Allergies:
Current Medications:

Consent for Services and Assignment of Benefits
(expires one year from date signed)

I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include screening, assessment, preventative dental treatment, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any assessments or treatment. I also understand that my child may be tested for HIV, Hepatitis B, or any other bloodborne disease should a health care worker be exposed to blood or bodily fluids. I authorize this health department to release dental information about my child, as permitted by HIPPA to his/her primary care physician, dentist, and school staff who may need to provide care in case of an emergency. I understand sharing this information is on a need to know basis only. I request that payment of authorized medical insurance benefits be made to the Purchase District Health Department on my behalf, for services my child receives. I also authorized this health department to release dental information about my child to Medicaid to determine payment for services. I understand by signing this consent, I acknowledge that I have received a copy of the Purchase District Health Department's Privacy Notice. I have read the above and I understand the items above as they apply to me and my child. Signature below indicates I do consent, authorize, and declare as stated above. Permission can be revoked at any time.

This program does not take the place of regular check-ups at a dental office. The services are being performed by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040.

_____ _____ _____

Signature Print Date