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 Program Manager

Floss and Gloss
Changing a kids world one tooth at a time!

Save/Print Form

Reset Form

CONSENT FOR DENTAL TREATMENT

School:	Teacher:		Grade:
Name:	Birthdate:		**Social Security Number REQUIRED**:
Address:	City:	St:	ZIP:
Race:	Hispanic: Y ☐ N ☐		Gender: M ☐ F ☐
Legal Guardian and Relationship to child:	Phone:		Email:
# 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 of legal guardian Print Date