**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: |

**Silver Diamine Fluoride**

|  |
| --- |
| I **DO NOT** consent to Silver Diamine Fluoride |

**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 Silver Diamine Fluoride informational flyer. 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 included in this packet 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.

This program utilizes asynchronous teledentistry visits (if applicable) for children with moderate and urgent needs with Medicaid to increase access to care. See enclosure.

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Signature of legal guardian Print Date