Healthy Futures Dental Consent
STUDENT INFORMATION

School Name			Grade Level
Student Legal First Name	Middle Initial		Last Name
Date of Birth		Gender: ☐ Male ☐ Female	

Race: ☐ American Indian/ Alaskan Native ☐ Asian ☐ Native Hawaiian/ Other Pacific
☐ Black/ African American ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Street Address		
City	State	Zip Code
Phone Number	Email	
Parent/Guardian Name		Date of Birth

ALREADY A PATIENT?

☐ Check box if student is already an existing patient of:
Heartland Community Health Center
Douglas County Dental Clinic
Bright Smiles Program
Friendly Smiles Program

INSURANCE INFORMATION

☐ No Dental Insurance

☐ KanCare/Medicaid # ______________________________

☐ Aetna ☐ United HealthCare ☐ Sunflower

☐ Commercial/ Private Insurance

Insurance Company	Policy #	Group #
Subscriber Name	Subscriber DOB	
Subscriber SSN	Employer	
Insurance Company's Address & Phone #		

MEDICAL HISTORY

Check all that apply

- [ ] HIV/AIDS
- [ ] Blood Disorder
- [ ] Artificial Heart Valve
- [ ] Artificial Joint/ Pins/ Screws
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Asthma
- [ ] Congenital Heart Disorder
- [ ] Heart Murmur
- [ ] ADD/ADHD
- [ ] Autism
- [ ] Anemia
- [ ] Seizure Disorder
- [ ] Hepatitis

List other medical conditions or special health care needs

Is your child required by a physician to take a pre-medication (antibiotic) prior to dental treatment?

- [ ] No
- [ ] Yes, condition:

ALLERGIES

Check all that apply

- [ ] Latex
- [ ] Amoxicillin/Penicillin
- [ ] Lactose
- [ ] Other
- [ ] Other: ______________________________

MEDICATIONS

List all medicines, vitamins, herbs, and home remedies the student is taking.	

The Healthy Futures Dental Outreach Team will provide on-site dental care to your child while they are at school. If there are services (listed below) that you do **not** wish for us to perform, please indicate here:

CONSENT FOR TREATMENT

As parent or legal guardian of the patient named above, I give Heartland Community Health Center permission to provide my child with comprehensive dental care. Comprehensive care includes dental sealants, fluoride varnish, silver diamine fluoride treatment, x-rays, dental cleanings, fillings, pulpotomies, extractions, and numbing of the mouth. I also acknowledge that the Privacy Practices were and are available for my review. This consent is valid until revoked in writing by Parent/Guardian.

I understand that all patient information is protected and will only be exchanged with staff employed/contracted by Heartland Community Health Center and, in certain circumstances, with the school (applicable only if your child's treatment occurs as part of a school-based program). I authorize Heartland to release the information necessary to process insurance claims and authorize payment directly to Heartland.

Parent/Guardian Signature	Date