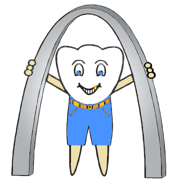

IN SCHOOL DENTAL CARE

Please complete sign & return to school. Questions? Please call (314) 872-3930

Taking care of your child's teeth is important to keep them healthy.

CHILD

1. TELL US ABOUT YOUR CHILD

☐ To decline services, check here and complete "Student Name & "Birth Date" only.

Student Name____Male/ Female
(PLEASE PRINT CLEARLY) FIRST NAME LAST NAME CIRCLE ONE

Student Birth Date_____/_____/_____Race_______________School______________
MM/DD/YY (OPTIONAL)

Teacher_______________________District_______________Grade_____Room#_____

Your Name_____________________________Relation to Student ☐ Custodial parent ☐ Legal guardian
CHECK ONE

Address___________________________City_____________State_____Zip_____

Email_______________________Phone( )___________2nd Phone( )___________

2. CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

- ☐ Recent Dental Problems
- ☐ Latex Allergy
- ☐ Allergy to Medications/Other
- ☐ Asthma or Wheezing
- ☐ Behavioral Problems
- ☐ Heart Problems/Murmur
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Hemophilia/Bleeding Problems
- ☐ Sickle Cell Anemia
- ☐ Anemia/Fainting
- ☐ Epilepsy/Seizures
- ☐ Liver Problems/Hepatitis
- ☐ Kidney Problems
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Communicable Diseases

Notify us of any medical history changes. A thorough complete medical and dental history are important for a proper dental examination and evaluation.

List allergies______________________________

Name/phone # of child's physician______________________________

Use space below to provide additional details on your child's health, including current medical treatment, other significant past illnesses, alcohol & tobacco use (including smokeless). List current medications. Attach another page as needed.

____

Approx. date of last dental visit. ______________________________

INSURANCE

3. DENTAL INSURANCE INFORMATION

CHECK ONE **Medicaid covers 100% of Treatment**

☐ CHILD HAS MEDICAID: Missouri Medicaid Envolve United Health Care Liberty ______________

Enter Child's ID Number HERE: ☐☐☐☐☐☐☐☐☐

☐ CHILD HAS PRIVATE DENTAL INSURANCE

ID# ______________________________Group #______________

Name of Plan ______________Name of Insured Parent______________Parent DOB__________

Parent SSN ______________________________Employer______________

Work Phone ______________________________Insurance Phone______________

☐ CHILD IS UNINSURED

SERVICES

4. CHECK TOTAL CARE OR PREVENTIVE CARE (Check only one)

Total Care

☐ Oral hygiene instructions, dental exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, baby teeth root canals and removal of hopeless teeth.

Preventive Care only

☐ Oral hygiene instructions, dental exams, x-rays, cleanings, fluoride, and sealants.

By signing this consent form I give consent to the Gateway to Oral Health Health Foundation affiliated general dentists to provide dental care to my child at school without my presence unless I withdraw this consent. I also authorize and direct Gateway to Oral Health Foundation to bill and collect payment from any Medicaid, Insurance, or third party payer that covers the services provided to this patient. I agree to pay any portion of the charges not covered by the insurance. Photographs may also be taken and used as an educational/marketing tool for our program. Once signed, this consent form is valid for the entire school year.

SIGN HERE ______________________________ ______________
DATE

Print name______________________________ **FOR YOUR PRIVACY PLEASE FOLD & SECURE**