ATCHISON COMMUNITY HEALTH CLINIC

1412 N. 2nd Street
Atchison, KS 66002
913-367-4879 www.achcks.org

Dental Consent Form

The "Open Wide Dental Hygiene Program" from the Atchison Community Health Clinic will be providing dental services at your child's school this year. All children are invited to participate in the program, but the program is especially designed to provide dental services to children that are not receiving services elsewhere. *If your child already has a dental home, or has seen a dentist within the 6 months, please continue to see your dentist for regular cleanings and checkup!*

School Name: _____ **Teacher:**_____

Student Name: _____ **DOB**:_____ __ **Grade:** _____

Gender: _____ **Sexual Orientation/Gender Identity**_____ ☐ **Choose not to answer**

Race: ___American Indian or Alaskan Native ___Asian ___Native Hawaiian or Other Pacific Islander
___Black or African American ___White ___Other Race

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino

Does the child have dental insurance? Yes No
If yes, complete the insurance section below. We will bill your insurance for services provided.

☐ **KS Medicaid** - Please circle one: Sunflower Aetna Better Health United Health Care

Medicaid # _____ Title Number _____

☐ **Commercial/Private Insurance:**

Subscriber Name _____ Subscriber DOB _____ Subscriber SSN# _____

Insurance Company _____ Policy # _____ Group # _____

Parent/Guardian name: _____ Daytime phone #:_____

Parent/Guardian Address:_____ City: _____ State ___ Zip:_____

Email address:_____

As parent or legal guardian of the patient named above, I give Atchison Community Health Clinic permission to provide my child with dental cleanings, fluoride, sealants and or temporary fillings if indicated. I also acknowledge that the Privacy Practices were and are available for my review. This consent is valid for one year from the Parent/Guardian Signature date below. I authorize Atchison Community Health Clinic to submit all services to my insurance company and to collect payment on my behalf. I understand that I am responsible for any copay or deductible amounts.

Parent/Guardian Signature: _____ **Date:** _____

☐ **Check if your child has a dental home and you DO NOT want your child to have services at school**

Please complete and sign the Medical History Form on the other side

Medical History Form

Student Name: _____ **DOB:** _____

When did your child last visit a dentist? □ In the past year □ More than a year ago □ Never

Why did your child visit the dentist? □ Checkup □ Cleaning □ Mouth Pain □ Filling □ Tooth pulled □ Other

Medical History: Check all that apply

□ Heart murmur □ Autism □ Asthma □ Diabetes □ Hepatitis □ Heart Disease
□ Artificial Joints Pins/Screws □ Artificial Heart Valve □ Congenital Heart Disorder
□ Seizure disorder □ Other_____

Any Known Allergies:

□ Latex □ Amoxicillin/Penicillin □ Other_____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? □ No □ Yes

If yes, for what condition_____

Does your child have special health care needs? □ No □ Yes
If yes, please explain:_____

Surgeries/Hospitalizations/Other Medical Conditions: _____

Medications your child is currently taking: _____

Other information- Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs.

_____

_____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature: _____**Date**: _____

****Please note, the federal government requires us to ask you for the following information. It is used for government reporting purposes only. No identifying information will ever be disclosed, including name, and we will not use this information for any other purpose.****
PLEASE CIRCLE YOUR FAMILY SIZE AND THE RANGE OF YOUR ANNUAL INCOME.

2019 ANNUAL FEDERAL POVERTY GUIDELINES

FAMILY SIZE				
1	$0.00 - $12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981 +
2	$0.00 - $16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821 +
3	$0.00 - $21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661 +
4	$0.00 - $25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501 +
5	$0.00 - $30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341 +
6	$0.00 - $34,590	$34,591 - $51,885	$51,886 - $69,180	$69,181 +
7	$0.00 - $39,010	$39,011 - $58,515	$58,516 - $78,020	$78,021 +
8	$0.00 - $43,430	$43,431 - $65,145	$65,146 - $86,860	$86,861 +

Please complete and sign the other side of this form