ATCHISON COMMUNITY HEALTH CLINIC – SCHOOL BASED DENTAL SERVICES

NEW PATIENT STUDENT INFORMATION										
Student Last Name (Legal): Student		dent First Name (I		Legal): MI: P		Prefer	Preferred Name:			
Student Date of Birth:	Student Sex	k at Birtl	h:	Student Ge	ender Identi	tv:	Student	Race:		
	☐ Male [☐ Fema								
				male, female, both, or neither						
Parent Home Phone #:	Parent Cell				□ Male			☐ Asian		
				☐ Female			☐ Black	☐ Black / African American		
☐ Permission to leave voicemail				☐ Transgender Male (F to M)) □ Nativ	☐ Native Hawaiian		
Is the Student homeless?	_			☐ Transgender Female (M to F)			F) 🗆 Pacifi	☐ Pacific Islander		
☐ Yes				☐ Something else:			☐ White	☐ White / Caucasian		
□ No	☐ Not Hispanic									
				☐ Choose	not to discl	ose				
Student Address:		City				Sta	te		Zip:	
KANSAS MEDICAID BENEF	ITS									
Does the student have Kan	Care?		□ KS M	edicaid l	☐ Sunflowe	r 🗆	United Healt	hcare	☐ Aetna	
☐ Yes ☐ No			☐ KS Medicaid ☐ Sunflower			· –	- Officed Fleatificate Aetila			
KanCare policy ID #:										
DENTAL INSURANCE INFO				Τ						
Primary Dental Insurance C	Company:			Primary Dental Insurance Address:						
Culturally and Final and Last No.				Codesanile	D-+	intle.	Cl l C -	-:-I C-		
Subscriber First and Last Name:				Subscriber Date of Birth: Subscriber Social Security #:						
Incurance Delicutty				Incurance Croup #						
Insurance Policy #:			Insurance Group #							
RESPONSIBLE PARTY / PAR	RENT / GUAR	DIAN IN	NFORMAT	ΓΙΟΝ						
Last Name:	-		First Na					MI:		
Social Security #: Phon			Phone	Number:				Date of Birth:		
Email Address:										
EMERGENCY CONTACT										
Name: Relationship to			onship to	Student: Phone			one number:	number:		
CONSENT TO TREAT										
Your child's school has agreed				-		-	•		_	
permission to provide dental services to my child. I acknowledge that the Privacy Practices were and are available for my review. I										
hereby state, to the best of my knowledge, the above information is complete and correct. I authorize ACHC to submit all services to my insurance company and to collect payment on my behalf. I understand that I am responsible for any co-pay, deductible or non-										
covered services. I understand ACHC offers a sliding fee discount. If interested in applying for the discount or you have questions										
about your bill it will be necessary to call the ACHC billing office at 913-367-4879.										
Parent/Guardian Name:										
- · /a /: ·				Τ						
Parent/Guardian Signature:							Date:	Date:		

2021 ANNUAL FEDERAL POVERTY GUIDELINES												
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 HOUSEHOLD SIZE AND INCOME*****												
1 Person in Household	2 People in	Household	3 People in	Household	4 People in Household							
\$0.00 - \$12,880	\$0.00 - \$	17,420	\$0.00 - 3	\$21,960	\$0.00 - \$26,500							
\$12,881 - \$15,971	\$17,421 -	\$21,600	\$21,961 -	\$27,230	\$26,501 - \$32,860							
\$15,972 - \$19,191	\$21,601 -	\$25,955	\$27,231 -	\$32,720	\$32,861 - \$39,485							
\$19,192 - \$25,760	\$25,956 -	\$34,840	\$32,721 -	\$43,920	\$39,486 - \$53,000							
\$25,761	\$34,8	341	\$43,921		\$53,001							
5 People in Household	6 People in	Household	7 People in	Household	8 People in Household							
\$0.00 - \$31,040	\$0.00 - \$	35,580	\$0.00 - \$	\$40,120	\$0.00 - \$44,660							
\$31,041 - \$38,489	\$35,581 -	\$44,119	\$40,121 - \$49,748		\$44,661 - \$55,378							
\$38,490 - \$46,249	\$44,120 -	\$53,014	\$49,749 -	\$59,778	\$55,379 - \$66,543							
\$46,250 - \$62,080	\$53,015 -	\$71,160	\$59,779 -	\$80,240	\$66,544 - \$89,320							
\$62,081	\$71,3	161	\$80,	241	\$89,321							
☐ Check here if your child has a dental home and you DO NOT want your child to have dental services performed at your child's school. Medical History Information												
When did your child last	Why did your											
visit a dentist?	child visit the	☐ Heart murmu	Allergies: ☐ Latex									
☐ In the past year	dentist?	☐ Seizure Disord		☐ Autism☐ Asthma	☐ Amoxicillin/Penicillin							
☐ More than a year ago	☐ Checkup	☐ Artificial Hear		☐ Other:								
□ Never	☐ Cleaning	☐ Heart Disease	_ = = = = = = = = = = = = = = = = = = =									
	☐ Mouth Pain	☐ Heart Disease ☐ Hepatitis ☐ Artificial Joints, Pins, Screws										
	☐ Filling	☐ Congenital He										
	☐ Tooth Pulled	☐ Other:										
	☐ Other											
Is your child required by ph	ysician to take pre	-medication (ant	tibiotics) prior t	o dental treatmer	nt? □ Yes □ No							
If yes, for what condition:												
Does your child have special needs? ☐ Yes ☐ NO If yes, please explain:												
2 222 , 2 m 2 m 2 2 2 2 2 m 2 m 2 m 3 2 m												
Surgeries/Hospitalization/Other medical conditions?												
Sargeries/ 1103pitanzation/ Other inedical conditions:												
Is your child currently taking medication? \square Yes \square No \square If yes, please list the medication(s).												
Other information – Please tell us anything 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 the above information is accurate to the best of my knowledge and I will contact the school as soon as												
possible if any changes occ					B.1.							
Parent/Guardian Signature	:				Date:							