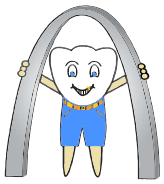
# IN SCHOOL DENTAL CARE

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 Missouri Care _____

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**

Gateway to Oral Health Foundation
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