FLINT HILLS
COMMUNITY HEALTH CENTER
YOUR HEALTH + MORE

Dental outreach student Consent Form

STUDENT INFORMATION				Chart Number:
Grade:	**Teacher:**		**School:**	
STUDENT'S Last Name:		**First Name:**		
Date of Birth:	**Age:**		**Gender:** □ Male □ Female	
Mailing Address:	**Apt. No.:**	**City:**	**State:**	**ZIP:**
Phone Number:				
Race: □ White □ Black/African-American □ More than 1 race □ Asian □ Other Pacific Islander □ American Indian/Alaska Native □ Native Hawaiian			**Ethnicity:** □ Latino/Hispanic □ Other	
PARENT/GUARDIAN Name:		**Relation to Student:**		
Mailing Address:	**Apt. No.:**	**City:**	**State:**	**ZIP:**
Please mark the box next to each service you would like your child to receive: □ Sealants □ Cleaning □ Fluoride				

HEALTH HISTORY (required)

□ Diabetes □ Anxiety/Depression □ Asthma □ Heart murmur □ ADD/ADHD □ Heart disease
□ Autism □ Artifical heart valve □ Hepatitis □ Seizure disorder □ Congenital heart disorder
□ Artificial joints/pins/screws □ Other _____
Known allergy to: □ Latex □ Amoxicillin/Penicillin □ Other _____

Please list all medications your child is currently taking:_____
_____

Does your child require a pre-medication (antibiotic) prior to dental treatment? □ Yes □ No

Name of child's dental home and date of last visit: _____ _____/_____/_____

INSURANCE INFORMATION (required): Please fill out the following information about your CHILD:

By completing any portion of this form, you are authorizing FHCHC to provide dental services for your child and to collect payment from KanCare and/or Private Dental Insurance.
□ None

□ KanCare #: _____
□ United Health Care □ Aetna □ Envolve

□ Private Insurance - Name of Company: _____

ID#: _____ Group #: _____

Subscriber Information (All information must be provided):

Last Name:	First Name:	Date of Birth:	Social Security Number:
Address:	City:	State:	ZIP:
Employer:	Relationship to Child:		
Parent/Guardian Signature:		**Date:**	