Children's Dental Health Services

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www.twentyteeth.org | 507-529-0436
903 West Center Street • Suite 130 • Rochester, MN 55902

Children's Dental Health Services provides dental care services including teeth cleanings, oral hygiene instructions, fluoride varnish, sealants, exam and x-rays. Services provided are reserved for children 21 and under, who are eligible for the free/reduced lunch program at their school, or on medical assistance. Please complete ONE FORM PER CHILD.

STOP **Do not fill out this form if your child has private dental insurance or an established dental home** STOP

Parent/Guardian Consent Form: (Please print clearly and complete the ENTIRE form)

Child's First Name _____ Middle Name_____ Last Name _____

Child's School _____ Grade _____ Teacher _____
(If applicable)

Date of Birth: ____/____/____ Age: _____ ☐ Male ☐ Female
Month / Day / Year

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Native American ☐ Other

☐ Yes ☐ No Is an interpreter needed? If yes, list language: _____
Who needs an interpreter? ☐ Child ☐ Parent

☐ Yes ☐ No Does your child have any diseases or health problems? If yes, list: _____

☐ Yes ☐ No Does your child take any medications? If yes, list:_____

☐ Yes ☐ No Does your child have any allergies? If yes, list: _____

☐ Yes ☐ No ☐ Unsure Is your child eligible for Free/Reduced Lunch?

☐ Yes ☐ No Has your child had a dental cleaning in the last 6 months?
If yes, where?_____ When? _____

☐ Yes ☐ No Does your child have medical assistance?

How do you pay for your child's dental care? If medical assistance, please select and list ID# or PMI#:_____

☐ U-Care ☐ BluePlus ☐ MA ☐ Medica ☐ South Country ☐ Community Health Voucher ☐ Insurance through work ☐ Self

- I acknowledge I am able to exercise my rights under HIPAA and privacy rules of the Health Insurance Portability Accountability Act of 1996 while being able to request additional information at any time by contact Children's Dental Health Services at 507-529-0436.
- I understand these services are provided by a dental hygienist and are not a substitute for a recommended annual exam provided by a dentist.
- I understand this health and consent form is valid for 12 months effective upon the signing date.
- I have the right to revoke this consent at any time by giving written notice to Children's Dental Health Services.
- I understand this information will only be used for dental clinic information limited to our staff, referring dentist, school and public health staff whose work assignments reasonably require access to this data.
- I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, and health care operations. I also give Children's Dental Health Services permission to send me appointment reminders via text messages.
- I consent to allow pictures of my child to be taken and possibly used in newspapers, web, or for promotional use of Children's Dental Health Services.
- Please print NO if you do not consent to the photo portion of the form:_____

By signing below I give my consent for my child to participate in Children's Dental Health Services School-Based Dental Program. To the best of my knowledge, the medical history questions have been answered correctly and accurately.

_____

Print name of Parent/Guardian **Signature** **Date**

SUBMIT