



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**.

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

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| Parent/Guardian Consent Form: (| (Please print clearly and comp | lete the ENTIRE form) | | |
|---|---|---|---|--|
| Child's First Name | Middle Name | Last Name | | |
| Child's School(If applicable) | Grade | Teacher | | |
| Date of Birth:/ Age: | | ıale Email Address_ | | |
| Address:Street | City | State | Zip Code | |
| Home Phone: | Cell Phone | x | | |
| Race/Ethnicity: Caucasian African An | merican 🗆 Hispanic 🗆 | ☐ Asian/Pacific Islander | □ Native American □ Other | |
| ☐ Yes ☐ No Is an interpreter needed? If yes, list language: | | | | |
| ☐ Yes ☐ No Does your child have any diseases or health problems? If yes, list: | | | | |
| ☐ Yes ☐ No Does your child take any n | medications? If yes, list: | | | |
| ☐ Yes ☐ No ☐ Does your child have any a | allergies? If yes, list: | | | |
| ☐ Yes ☐ No ☐ Unsure Is your child eligi | gible for Free/Reduced Lunch? | ? | | |
| ☐ Yes ☐ No Has your child had a dent | ntal cleaning in the last 6 month | hs? | | |
| If yes, where? | | When? | | |
| \square Yes \square No Does your child have dental insurance? | | | | |
| | ance type AND provide their M ☐ MA ☐ South Country | | | |
| I acknowledge I am able to exercise my rights under request additional information at any time by contact I understand these services are provided by a dental understand this health and consent form is valid for I have the right to revoke this consent at any time by I understand this information will only be used for deassignments reasonably require access to this data. I understand that by signing this consent form, I am payment, and health care operations. I also give Chill I consent to allow pictures of my child to be taken and Please print NO if you do not consent to the photo per consent to the | ct Children's Dental Health Services a tal hygienist and are not a substitute for 12 months effective upon the sign by giving written notice to Children's l dental clinic information limited to our a. In giving my consent to your use and hildren's Dental Health Services perm and possibly used in newspapers, we | at 507-529-0436. e for a recommended annual ening date. Dental Health Services. r staff, referring dentist, school disclosure of my protected hemission to send me appointment. | exam provided by a dentist. nol and public health staff whose work nealth information to carry out treatment, nent reminders via text messages. | |
| By signing below I give my consent for my Program. To the best of my knowledge, the Print name of Parent/Guardian | | ons have been answer | | |