Fluoride Consent

FLINT HILLS COMMUNITY HEALTH CENTER
YOUR HEALTH + MORE

Student Information (required)

Chart # _____

Grade_____ Teacher_____ School _____

DOB_____/_____/_____ Age_____ Gender ☐ Male ☐ Female Phone #_____

Student Name _____

Street Address_____ Apt. #_____

City_____ State _____ Zip Code _____

Parent/Guardian Name_____ Relation to Student _____

Name of child's dental home and date of last visit

_____ ____/____/____

Race/Ethniciy (check all that apply)

- ☐ White
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ Native Hawaiin/Pacific Islander
- ☐ Hispanic
- ☐ Other

If you have KanCare or private dental insurance, FHCHC will directly bill to your insurance provider for services completed. If you do not have insurance, there is no charge to you. There will be no out-of-pocket cost to you at the time of service nor will you be billed by FHCHC at anytime for school-based activities.

Insurance Information (required) Please fill out the following information about your CHILD:

☐ Sunflower ☐ Amerigroup ☐ United Health Care ☐ Private ☐ None

Name of subscriber (individual who carries the insurance) _____

Name of dental insurance company_____ ID #_____

Group #_____

Policy Holder's SS#_____ Policy Holder DOB____/____/____ Employer _____

I give permission to Flint Hills Community Health Center to provide screening/fluoride services for my child and to collect payment from Kancare and/or my private insurance company.

This form must be signed in order for your child to receive a fluoride varnish application.

Parent/Guardian _____ Date _____

(Please do not detach)

_____ I DO NOT want my child to participate in the free dental screening

Student's Name _____ Grade/Teacher _____

Parent/Guardian _____ Date _____