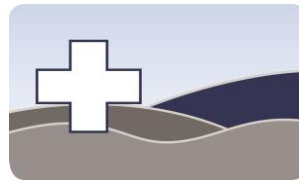


Fluoride Consent



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/Ethnicity (check all that apply)

- White
- Asian
- American Indian/Alaska Native
- Black/African American
- Native Hawaiiin/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:			
<input type="checkbox"/> Sunflower	<input type="checkbox"/> Amerigroup	<input type="checkbox"/> United Health Care	<input type="checkbox"/> Private	<input type="checkbox"/> None
Name of subscriber (individual who carries the insurance) _____				
Name of dental insurance company _____			ID # _____	
Policy Holder's SS# _____			Policy Holder DOB ____/____/____	Employer _____
			Group # _____	

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