PIKE COUNTY HEALTH DEPARTMENT *BRIGHT SMILES @ SCHOOL*
Patient Registration and Consent Form

Please complete form and return if you would like for your child to have the services listed below. ***Please fill out this form today and return it to your child's teacher. Please print (All questions refer to the child for whom services are requested.) With your permission, a dental hygienist will provide your child with:***

- **A dental assessment of the condition of the mouth and teeth**
- **An age-appropriate dental cleaning**
- **Fluoride Varnish (to prevent future cavities)**
- **Dental Sealants (long-lasting plastic coatings over the back teeth)**
- **Oral Hygiene Instruction including nutrition counseling**
- **A personal Dental Report Card**

(If NO services are needed, please complete CHILD'S NAME ONLY)

1. _____ _____ _____ 2. _____-_____-_____ 3. _____/_____/_____ 4. SEX (Check One) ❑ MALE ❑ FEMALE
CHILD'S NAME: Last First Middle SOCIAL SECURITY # BIRTHDATE

5. _____ _____ _____ _____ _____
MAILING ADDRESS CITY COUNTY STATE ZIP

6. _____ 7._____ 8. ETHNICITY (Check One) ❑HISPANIC or LATINO ❑ NOT HISPANIC OR LATINO
SCHOOL GRADE/TEACHER

9. RACE (Check One) ❑ WHITE ❑ BLACK or AFRICAN AMERICAN ❑ AMERICAN INDIAN or ALASKA NATIVE ❑ASIAN ❑NATIVE HAWAIIAN

10. Parent/Guardian Name: _____Relationship to child:_____Phone (H) _____(C) _____(W) _____

11. Does your child have a dentist? YES NO If so, who? _____ Date of last cleaning: _____

12. Does your child need premedication before a cleaning? YES NO 13. Does your child have any allergies to food or to medicine? YES NO If yes, please list_____

14. List any current medication your child takes (include over the counter medication or herbal medication) _____ 15. Does your child have any illnesses, diseases, or conditions including, ADHD, asthma, heart conditions, diabetes, contagious diseases? Yes No **Please explain:** _____

16. Does your child have a Medicaid Card? (Check One) ❑ Yes ❑No ❑Applied/ Pending ❑KCHIP If Yes, MEDICAID Card Number _____
If yes to Medicaid check one: ❑ Aetna Better Health (Coventry) ❑Well Care ❑Anthem ❑Humana Care Source ❑Passport

CONSENT FOR HEALTH SERVICES: (Expires 1 year from date signed)
Of my own free will I consent to care which may include screening, exams, treatment, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue. This program does not take the place of regular check-ups at a dental office. The preventive dental services are being done by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Dentist Board member for your county is Dr. James Justice of Elkhorn Dental, who is supportive of the standards of practice of the public health hygienists and work with your Board of Health to develop and adopt protocols for these services.

This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA). I understand by signing this consent, I acknowledge that I have access to a copy of the Pike County Health Department's Privacy Notice located at www.pikecountyhealth.com/v3/uploads/documents/pchd_hipaa_pp.pdf or I may request a copy by calling Pike County Health Department's main office at (606) 437-5500. I understand that my child may be screened to check the retention of these sealants by the public health dental hygienist during the following school year.

_____ _____
Signature of Parent/Guardian or other Authorized Person *Date*

Please sign and date this section if you have Medicaid (PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS) ❑ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to the local health department on my behalf, for services received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420. **I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated above.**

_____ _____
Signature of Parent/Guardian or other Authorized Person *Date*

Please return to your child's homeroom teacher.
If you have any questions, please contact the Pike County Health Department at (606) 437-5500