Chart #__________

School Year 2024-2025

School Based Dental Consent for Services Sterling Health Care, Inc.

The Dental Providers (Sterling Health Care, Inc.) will offer dental services that include, but are not limited to Dental exams, X rays, Fluoride Varnish and Sealants. Please review this form carefully and complete all information that is requested. **The Providers cannot/will not provide service to your child without this signed consent.** The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing. This service is intended for students who are not established with their own dentist or for parents requesting to now have this service done at school.

Student's School:______________________________**Grade**:____________________**Teacher:**______________________________

Last Name: __________________________**First Name**:__________________________**Middle Name:** ________________________

Gender: M/F **SSN:**__________________________Birth **Date:**__________________________**Nickname:**____________________

Race: □White □Black/African American □Asian □American Indian/Alaskan Native □Native Hawaiian □ Other

Ethnicity: □Hispanic/Latino □Non-Hispanic/Non-Latino **Primary Language:**__________________**Interpreter Needed?** □Yes □No

Address:____ **Zip Code**:___________________________

Contact Phone: ______________________**Work Phone:** _________________**Email Address:** ______________________________

Preferred Communication: Phone/Email

Dental Information:

Does your child have a dentist? □Yes □No

Do you want your child to be seen by a dental provider at school? Yes ________No________

In case of emergency, please contact:

Name of Mother/Legal Guardian:____

Home Phone: ________________________**Cell Phone:** __________________________**Work Phone:**_________________________

Name of Father/Legal Guardian:____

Home Phone: ______________________________**Cell Phone:**__________________**Work Phone:**_________________________

Student's Doctor: _________________**Student's Dentist:**_______________________**Pharmacy:**_________________________

INSURANCE INFORMATION:

This information is **required** for the student's health record to be complete but will ONLY be billed if services are provided by the Dental Provider.

Birth Mother's Full Name:________________________________**DOB:**__________________**SSN:**__________________________

*Only required if Birth Mother is still on student's insurance.

Does the student have Medical Insurance? □Yes □No

Primary Insurance: _________________________________ **ID#**_________________________ **GROUP#**____________________

Secondary Insurance: _______________________________**ID#**_________________________ **GROUP#**____________________

Policy Holder Name:____**Policy Holder Date of Birth:**___________________________

Policy Holder Gender: □Female □Male **Policy Holder Phone:**______________________**Policy Holder SSN:**__________________

Policy Holder Address if different from Patient:____

Does the student have Dental Insurance? □Yes □No

Primary Dental Insurance: ___________________________ **ID#**_________________________ **GROUP#**____________________

Secondary Dental Insurance: _________________________**ID#**_________________________ **GROUP#**____________________

Policy Holder Name:____**Policy Holder Date of Birth:**___________________________

Policy Holder Gender: □Female □Male **Policy Holder Phone:**______________________**Policy Holder SSN:**__________________

Policy Holder Address if different from Patient:____

Student's Medical History:

The following information will assist the School Based Dental Team in making an accurate assessment of your child in case of illness or emergency.

ALLERGIES: Please list all medications, vaccines, food or any other allergies

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

Any Hospitalizations? □Yes □No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

Any Surgeries? □Yes □No

Type of Surgery	Date of Procedure	Facility Where Procedure Was Performed

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N	Condition	Y	N
Allergies			Heart Murmur			Chicken Pox		
Asthma			Wheezing			Urinary Tract Infection		
Eczema			Pneumonia			Acne		
Seizures			Ear Infections			Serious Injury or Concussion		
Developmental and/or Speech Problems						ADHD/ADD		
Diabetes						Other		
If Other Please Explain:								

FAMILY HISTORY: Do any family members have any of the following conditions?

Condition	Relative	Condition	Relative	Condition	Relative
Heart Attack	Age:	Pancreatic Cancer		Migraine	
High Blood Pressure		Any other Cancer		Seizures	
Congestive Heart Failure		Colitis		Diabetes	
Rheumatic Heart Disease		Crohn's Disease		Goiter	
Congenital Heart Disease		Colon Polyps		Bleeding Tendency	
Breast Cancer	Age:	Hepatitis		Suicide	
Colon Cancer	Age:	Stomach Ulcer		Mental Illness	
Leukemia		Kidney Disease		Tuberculosis	
Melanoma (skin cancer)		Stroke		Other	
Ovarian Cancer		Asthma		Drug or Alcohol Abuse	

When was the last time your child was seen by a doctor?

Doctor's Name: ____**Reason:** ______________________**Date:**__________________________

Immunization Status: Is your child up to date on immunizations? □Yes □No

Where is the child's immunization record on file: ____

□Yes, I give permission for school nurse to provide a copy of immunization record

Other:

Do you have concerns about your child's health? □Yes □No Does your child smoke and/or use tobacco products? □Yes □No

Does your child drink alcohol? □Yes □No Is your child exposed to secondhand smoke? □Yes

When was your child last seen by a dentist?

Dentist's Name: ____**Reason:** ______________________**Date:**__________________________

Has your child ever been shown how to brush and/or floss? □Yes □No

How many snacks per day does your child eat? □None □1-2 □3-4 □5-6 □More than 6

Is your child required by a physician to take a pre-medication (antibiotics) prior to dental treatment? □Yes □No

If yes, please explain:____

Does your child have special healthcare needs? □Yes □No

If yes, please explain:____

Dental Caries Risk Assessment

Please circle the appropriate response for each question in the section below:			
Is your child exposed to fluoride (through tap water, supplements, professional applications, or toothpaste)?	Yes	No	
Does your child have a dentist they see regularly?	Yes	No	
Does your child have an eating disorder?	No	Yes	
Does your child abuse drugs or alcohol?	No	Yes	
How often is your child eating and/or drinking sugary foods or drinks (including candy, juice, soft drinks, energy drinks)?	Primarily at mealtimes		Frequently during the day
Has your child ever had chemo/ radiation therapy?	No		Yes
Does your child have any special health care needs (developmental, physical, medical, or mental disabilities) that prevent regular oral health care?	No	Yes (child over age 14)	Yes (child age 6-14)
When was the last time the child's parent/guardian had a cavity?	No cavities in the past 24 months	1 or more cavity in the last 7-23 months	1 or more cavity in the last 6 months

OFFICE USE ONLY:			
Cavitated or non-cavitated (incipient) carious lesions or restorations (visually or radiographically evident).	No new carious lesions or restorations in last 36 months	1 or 2 new carious lesions or restorations in last 36 months	3 or more carious lesions or restorations in last 36 months
Teeth missing due to caries in the past 36 months	No		Yes
Visible plaque	No	Yes	
Unusual tooth morphology (that compromises oral hygiene)	No	Yes	
Interproximal restoration – 1 or more	No	Yes	
Exposed root surfaces (present)	No	Yes	
Restorations with overhangs and/or open margins; open contacts with food impactions	No	Yes	
Dental/Orthodontic appliances (fixed or removable)	No	Yes	
Severe xerostomia	No		Yes

For Office Use Only:	Provider:	**(a)**	**(b)**	**(c)**
	Date:			

I understand that I am authorizing the rendering of dental diagnostic and treatment procedures. Procedures include: clinical exams, fluoride treatment, cleanings, x-rays, silver and/or white fillings, stainless steel crowns, nerve treatment, soft tissue removal, and all local anesthesia by authorized agents and employees of Sterling Health Care and the dental staff, or their designees, as may in their professional judgment be deemed necessary or beneficial.

I understand that certain risks and complications may happen if my child has these procedures. These possible problems include: The possibility of discomfort during and following treatment, aspiration or swallowing a dental instrument or dental material, allergic reactions to dental materials, and other possible problems that the dentist cannot predict.

There may be instances where the DMD is unable to save a tooth when trying to restore it. In these instances, the only alternative is to extract (pull) the tooth. There are risks involved with having teeth removed. While infrequent, these risks may include: pain, excessive bleeding, infection, swelling, bruising, jaw stiffness, damage to adjacent or underlying teeth, breaking of a root tip, etc. I authorize the extraction of the tooth if the DMD is unable to save it. I understand that my child may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. I also understand that when baby teeth are removed, it can cause problems for the erupting teeth and my child may need a space maintainer to keep the space open for the permanent tooth to come in. I also understand that space maintainers are not placed as a part of this program and that a referral letter will be sent home if necessary.

There also may be instances when treatment on a tooth cannot be immediately performed, but in order to prevent an abscess or further infection, we may place a topical fluoride to stop the active decay process. While there are no health risks involved, black or dark staining of the decayed surface can occur. I authorize Sterling Health Care dental personnel to apply this material at their discretion.

I understand that my child may be provided a referral to a pediatric specialist if there is limited cooperation or if the DMD determines the child's treatment needs exceed the limits of a mobile dental clinic.

While all the individual records are held by Sterling Health Care as confidential, I understand that a list of children who need follow-up dental treatment is routinely provided to the Family Resource Center.

Permission to Communicate: There may be a need to communicate with you or the emergency contact provided above concerning your child's medical history, treatment or oral health needs. I understand that I am giving you permission to communicate with me or the emergency contact provided above through written notes sent home with my child, as well as any other method expressed on the consent form.

INCOME: *****Note: Sterling Health Care, Inc. Center is dedicated to providing health care to the community. We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!***

Household Size: __________Family Income:___________________________________

Sterling Health Care, Inc. Center School Based Health Assignment of Benefits / Consent for Treatment

I consent to the customary tests, procedures that may be deemed necessary for treatment of my child's condition by members of the Dental Staff of Sterling Health Care, Inc. Center. Consent is hereby given for such visits to the school dental office for the purposes of examination, treatment, and procedures rendered by a Dental Provider. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment. I authorize payment of medical benefits to the supplier for services provided by Sterling Health Care, Inc. Center. I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me.

Authorize for Release of Medical Information

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records, as well as release of records to my child's primary care provider. Further, I release Sterling Health Care, Inc. Center and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

The information in this form is accurate and complete, to the best of my knowledge, and is only for use in the student's treatment, billing and processing of insurance benefits for which the student is entitled. I will not hold my medical provider, dental provider, Sterling Health Care, Inc. or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

In the event of emergency or other illness, I understand that the providers and staff of Sterling Health Care, Inc. will deliver any dental or medical care deemed necessary regardless of the accompanying of an adult. Unless we are notified in writing, Sterling Health Care, Inc. will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

______________________	______________________
Date	Signature of the Parent/Legal Guardian **(REQUIRED)**
Best **phone number** to reach you	**Email** to link you to Patient Portal for child's health record
Date	Signature of Witness

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

Date	Phone Number	Witness Name	Address
Date	Phone Number	Witness Name	Address