Office Only:
MRN#_____

School Dental Program

Please complete the consent form below. Thank you.

LAKESHORE community health care

Child's First Name: _____ **Last Name:** _____ **Date:** _____

Section 1:

Is your child presently being seen by a dentist? ☐ Yes* ☐ No **If you currently have a dentist, please continue care with them.*

Is your child currently a patient at Lakeshore Community Health Care? ☐ Yes ☐ No

☐ STOP **No, I do not give permission for my child to participate in the school dental program.**
**We welcome all patients. If you have already established care with a dentist, other than Lakeshore Community Health Care, we ask that you continue your care with them.*

☐ GO **Yes, I give permission for my child to participate in the school dental program.**
I hereby authorize Forward Health or my insurance company to be issued a claim for billable services. I understand that I may be billed for charges not covered by my co-pay or insurance.

Print parent/guardian name:_____ **Date of Birth:**_____ **Relationship to child:** ☐ Parent ☐ Step Parent ☐ Foster Parent ☐ Guardian ☐ POA

Does the child reside with you? ☐ Yes ☐ No *If you are not the parent of the child please provide documentation.*

If you would like to give permission for communication to additional persons, in regards to minor care or medication pick-up, list them here.

Name: _____ *Relationship to child:* _____ *Phone:* _____ ☐ *Check for Rx Pickup*

Address: _____ *City, State and Zip:* _____

If you have selected "GO" above, please provide complete information for Section 2 - Section 5.
Please fully complete these sections and sign on the back to prevent a delay in service.

Section 2:

Child's Date of Birth:_____ Grade:_____

School: _____

Home Address: _____

_____
City, State and Zip

Preferred Communication *(List: 1,2,3)*: ___Call ___Text* ___Email

Phone to Call: _____

Phone to Text: _____

Email:_____

**Standard text messaging rates may apply.*

Section 3:

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian
☐ Black/African American
☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race

Ethnicity: Hispanic/Latino ☐ Yes ☐ No

Speaks: ☐ English ☐ Spanish ☐ Hmong
☐ Other:_____

Needs an Interpreter: ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No

Section 4: What type of DENTAL insurance covers your child's dental services?

**No student will be refused services based on their insurance coverage.*

☐ **Forward Health/Medicaid/BadgerCare** Member ID #:_____

☐ **Private Insurance** (i.e. Delta Dental of WI, Anthem Dental, etc.)

Insurance Name: _____ *Member ID/Policy #:*_____

*Policy Holder Name:*_____ *Policy Holder Date of Birth:*_____

Group #: _____ *Insurance Company Phone:*_____

Claim Mailing Address: _____

☐ **No Insurance:** *Uninsured patients will be asked to pay a flat co-payment based on household size and earnings.*

Total # of family members in household _____ **Total household earnings GROSS** (before taxes) _____
☐ Monthly ☐ Yearly

Section 5: Please complete the Student Medical History Form on the back side of this page.

It may be necessary for a LCHC representative to contact you prior to your child's exam.
Please respond back to us to ensure that your child will be seen while we are at their school.

School Dental Program

LAKESHORE community health care

Section 5: Please fully complete the following questions.

Name of Medical Physician: _____ Date of last exam: _____

Medical Physician's phone: _____ Weight: _____

Name of Medical Insurance: _____ Height: _____

Yes ☐ No ☐ Does your child take any medications? If yes, please list them:

_____

Yes ☐ No ☐ Does your child have any allergies? If yes, please explain:

_____

Yes ☐ No ☐ Has your child ever had any serious illnesses or operations? If yes, please explain:

_____

Yes ☐ No ☐ Has your child ever taken a pre-medication (antibiotic) before a dental visit? If yes, please explain:

_____

Please explain: type of diseases, date of diagnosis, etc.

Yes ☐ No ☐ Down Syndrome: _____

Yes ☐ No ☐ Cerebral Palsy: _____

Yes ☐ No ☐ Autism: _____

Yes ☐ No ☐ Mental Disability: _____

Yes ☐ No ☐ ADD/ADHD: _____

Yes ☐ No ☐ Muscular Dystrophy: _____

Yes ☐ No ☐ Asthma: _____ Inhaler in their possession at school? ☐ YES ☐ NO

Yes ☐ No ☐ Anemia/Sickle Cell: _____

Yes ☐ No ☐ Heart Condition: _____

Yes ☐ No ☐ Rheumatic Fever: _____

Yes ☐ No ☐ Cancer: _____

Yes ☐ No ☐ Thyroid: _____

Yes ☐ No ☐ Liver Disease: _____

Yes ☐ No ☐ Kidney Disease: _____

Yes ☐ No ☐ Tuberculosis: _____

Yes ☐ No ☐ Parasites: _____

Yes ☐ No ☐ Epilepsy: _____ Date of last seizure: _____

Yes ☐ No ☐ Diabetes: _____

Yes ☐ No ☐ Skin Disorder: _____ Please list type/variety: _____

Yes ☐ No ☐ Pregnancy: _____ How many weeks: _____

Yes ☐ No ☐ Hepatitis: _____

Yes ☐ No ☐ Herpes: _____

Yes ☐ No ☐ HIV/AIDS: _____

Yes ☐ No ☐ STD: _____

Any other medical concerns:

I agree to have LCHC contact my medical physician to release medical information pertaining to my child's dental needs. I agree to the sharing of information between my child's school and the LCHC dental program.

Parent or Guardian's Signature: _____ **Date:** _____

This form is good for one year from signed date.