Office use only/ Uso de oficina			
Ready		Called pt	
Slide		Emailed pt	
Need F/R		Has parent in sys	
Needs Sig			
Scanned		ACCT#	

THE DENTIST IS COMING TO YOUR SCHOOL

If your child does not have a dentist and needs dental treatment, please complete, sign & return to your School Nurse.
If your child already sees a dentist regularly, continue to go to that dentist.

ABOUT YOUR CHILD -Please fill out a different form for each child.

School Name_____

Teacher_____Room #_____Grade_____

Child's Name_____
(Last) *(First)* *(Middle)*

Child's Social Security Number_____Child's Date of Birth_____

Parent/Guardian Name_____

Address_____

Email_____Phone No_____Other Phone No_____

INSURANCE INFORMATION –

☐ **My Child has MEDICAID/VIRGINIA FAMIS Insurance – (Covers 100% of treatment)**

If your child has one of the following insurance, please circle your child's insurance:
MEDICAID / FAMIS / Anthem Healthkeepers Plus / INTotal Health

Member ID #:_____ INTotal Health/Anthem YTD #:_____

☐ **My Child has PRIVATE Dental Insurance - Please attach a copy of the insurance card**

Insurance Company Name:_____ Insurance Company Phone:_____

Group #:_____Member ID/Policy #:_____

Insured Adult: Insured Adult Birth Date: Insured Adult Social Security #:

Insured Adult:_____ Birth Date: _____ Social Security #:_____

Employer Name of Insured Adult:_____ Employer Phone: _____

☐ **My Child has NO Dental Insurance**

Please attach your Free or Reduced Lunch verification letter. Neighborhood Health will contact you with more information.

PLEASE COMPLETE BOTH SIDES

Child Demographic Information

Race: ☐ African-American ☐ American Indian/Alaska Native ☐Asian ☐ White ☐ Native Hawaiian/Other Pac. Islander

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Other specify:_____

Gender: ☐Female ☐Male

CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

☐ Recent Dental Problems	☐ Sickle Cell Anemia	☐ Communicate Diseases/TB
☐ Asthma or Wheezing	☐ Fainting/Epilepsy/Seizures	☐ Rheumatic Fever
☐ Behavioral Problems	☐ Liver Problems/Hepatitis	☐ Diabetes
☐ HIV/AIDS	☐ Kidney Problems	☐ Hemophilia/Bleeding Problems
☐ Cancer	☐ Heart Problems – Describe_____	_____

ALLERGIES/ MEDICATION/OTHER: _____

Name of child's Physician: _____Phone # of child's Physician:_____

Preferred Pharmacy: _____ Pharmacy Address: _____

Provide addition details on your child's health, including: current medical treatment/illnesses, significant past treatment/illnesses, and alcohol &/or tobacco use: _____

Date of Last Dental Visit: _____

READ AND SIGN BELOW

Please read and SIGN next to each line

- _____**CONSENT FOR TREATMENT**: I authorize the employees and agents of Neighborhood Health to perform and hereby consent to such dental treatment and examinations, including extractions, sealants, and fillings.
- _____**NO GUARANTEE**: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examination.
- _____**FINANCIAL RESPONSIBILITY**: I understand that I am financially responsible for all charges, whether or not paid by insurance Neighborhood Health does not participate in **every** insurance plan.
- _____**DEEMED CONSENT FOR BLOOD TESTING**: I understand that under Virginia Law, if a health care provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.
- _____ **MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT**: I request that payment of authorized Medicaid benefits be made on my child's behalf for any services furnished by Neighborhood Health for dental services. I authorize any holder of medical or other information about me, to release to Neighborhood Health for Medicaid Services, the Virginia Department of Medical Assistance Services and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for dentist and other medical services to the dentist or organization furnishing the services and authorize such dentist or organization to submit claim to Medicaid for payment. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

I request that the dentist perform a dental check-up on my child at school which may include exam, clearing, fluoride, sealants and x-ray, as well as other dental work as needed, including fillings, extractions of infected baby teeth, numbing the mouth and teeth and other procedures as described more fully above. This permission includes future dental visits. I have read the IMPORTANT CONSENT INFORMATION ABOVE and understand and agree to its terms.

_____ _____

SIGNATURE of Parent/Legal Guardian **Relationship to Patient** **Date**

PLEASE COMPLETE BOTH SIDES