# CONSENT FOR DENTAL CARE

Dear Parent,

DentaMed Healthcare is offering comprehensive dental care for children in your child's school. The program includes a dental screening, cleaning, x-rays, simple extractions, fluoride treatments and oral health education. Children will also be given a free oral hygiene kit containing toothpaste, toothbrush and dental floss.

Please complete this form if you want your child to participate in the program:

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

***Child's Date of Birth**:_____-_____-_____ Female / Male Phone Number (_____) _____-_____

Child's Address:_____ County:

School: _____

Grade in 2018-19 (circle): EC/PK K 1 2 3 4 5 6 7 8 9 10 11 12

Child's Race/Ethnicity (Check all that apply): _____White _____African American/Black _____Asian
_____Hispanic _____American Indian / Alaska Native _____Native Hawaiian / Pacific Islander _____Other

I understand the nature of the treatment provided and authorize DentaMed Healthcare staff to provide dental treatment.

- I acknowledge that DentaMed Healthcare may use my child's information for treatment and may disclose it to my insurance company.
- I understand that this permission is effective for a period of twelve months in order to provide follow-up services, including restorative treatment, dental cleaning, application of sealants and multiple fluoride applications.
- I understand that if restorative treatment is necessary, my child's restorative treatment plan will be provided to me prior to treatment.
- I agree to the release of my child's treatment plan records so I can receive them from the school.
- I authorize the clinic to treat my child whether or not I am physically present at the clinic during a scheduled treatment.

My signature confirms my informed consent, my status as the legal custodian of the minor patient identified and my authority to grant this consent. I understand that I may contact DentaMed Healthcare at 414-877-0707 if I have questions.

_____/_____ Date ____/_____/_____

**(Print) parent/guardian** **(Signature) parent/guardian**

Does your child see a dentist on a regular basis (every 6 months)? YES / NO

Does your child have allergies to Colophony resin? YES / NO

Does your child have Medicaid (Medical Assistance, BadgerCare, Title 19)? YES / NO

**MA Number**_____

Does your child have private dental insurance? YES / NO

Name of Dental Insurance Company _____