Affinia Healthcare
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Main Number: 314-898-1700 • www.affiniahealthcare.org

DENTAL TREATMENT CONSENT FORM

Affinia Healthcare Dental team can provide dental services at your child's school. Your child's participation is voluntary. **In order for you to receive these services; you must provide all information requested below. This consent is valid for one year.**

TELL US ABOUT YOUR CHILD

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Sex: □Male □Female **Date of Birth** _____/_____/_____ **Social Security #:**_____ - _____- _____
Home Address: _____ **Zip:** _____
School _____ **Grade** _____
Parent/Guardian Name (please print): _____ **Relationship:** _____
Cell Phone #: (____) _____ **Home Phone #: (____)** _____ **Work Phone #:(____)** _____
Email Address: _____ **Language spoken at home:**_____
Emergency Contact: _____ **Relationship:** _____
Phone #: (_____) _____

Ethnicity, Race, and Housing *(For Statistic Purposes Only)*

Ethnicity: □ Hispanic or Latino □ Non Hispanic or Latino

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

If yes, which type: □Public Housing □ Section 8 Housing □ Housing Voucher Program □ Subsidized Housing
□ Other (please list type _____)

Does your family live in a Homeless Shelter or without housing at this time? □Yes □ No □ Decline to report

Health History: Please check any history of/or difficulty with any of the following:

	Anemia		Diabetes		Hearing Disorder		Mental Disorder
	Asthma		Ear Infections (frequent)		Heart Murmur		Pregnancy
	Back Problems/Scoliosis		Ear Surgery		Hepatitis		Physical Problems
	Behavioral Issues		Eczema		High Blood Pressure		Seizures/Epilepsy
	Bleeding Disorder		Eye/Vision Problems		HIV/Aids		Sickle Cell Disease
	Congenital Heart Defect		Eye Surgery		Kidney Problems		Tuberculosis (TB)
	Cystic Fibrosis		Fainting		Lead Poisoning		Other _____
	Dental Problems		Headaches (frequent)		Liver Disorder		**None of these listed**
	Allergies, please describe type: □ Food_____ □ Latex_____ □Medication_____ □Seasonal_____ □ Other _____ Describe type of reaction: _____						
	Hospitalization date(s), please describe problem:						
	Surgery date(s), please list reason for surgery:						
	Please explain any item checked above:						
	Please list any medications your child is taking:						
	Any other concerns or comments: _____ _____ _____						

Insurance

Do you have a medical doctor? □Yes □No if yes, when was the last time your child saw his/her doctor for a physical or well child exam? Provider/Clinic: _____ Date: _____/_____/_____

Preferred Pharmacy (If M.D. or Nurse Practitioner feels you would benefit from medications):
Pharmacy Name: _____ Pharmacy Location: _____ Phone: _____

***Do you have health insurance*? □Yes □ No**
If yes, do you have health insurance with one of the following plans?

MO Health Net □Yes □No If yes, please specify plan; □ Aetna **Better Health** Plan # _____
□**Home State** Plan # _____ □ Missouri **Care** Plan # _____

Missouri Medicaid □Yes □No If yes, Plan or DCN #_____

Other Medical Insurance □Yes □No If yes, Plan Name and #_____

I give consent for payment of authorized insurance carriers to be made on my behalf of Affinia Healthcare for any services furnished to my child. _____ (initial)

Permission for Affinia Health Care Services

I give consent for the following (more than one service may be checked, please check which services are being offered):

Total Care

□ **I interested in Affinia HealthCare affiliated general dentists providing total dental care and oral hygiene instructions to me which may include dental exams, x-rays, cleanings, fluoride vanish, fillings, crowns, extractions. When an exam is performed and cavities are found, Affinia HealthCare will contact me through my nurse indicating all the cavities that have been found, the treatment needed and consent to perform only as needed as stated above. I can also ask to speak to the dental provider if I have questions. . I authorize and direct Affinia HealthCare to bill and collect payment from any Medicaid, insurance, or other third party payer that covers the services provided to this patient, which may be conducted by your insurance carrier and other governing bodies**

* (All patients requiring an extraction will be given a second consent form (tooth number) for permission).

□ If ***you do not consent for certain portion the dental treatment, please indicate which service(s) you would like excluded:*** _____

Preventive Care Only

□ I understand and give consent to the Affinia HealthCare affiliated dentists to provide dental care and oral hygiene instructions to my child which will ONLY **include dental exams, x-rays, cleanings, fluoride varnish, sealants at school without my presence unless I withdraw this consent. I understand my child will not receive fillings, crowns, extractions, baby root canals or spacers. I authorize and direct Affinia HealthCare to bill and collect payment from any Medicaid, insurance, or other third party payer that covers the services provided to this patient, which may be conducted by your insurance carrier and other governing bodies.**

Please note, this consent is valid for one year

I give permission for Affinia Healthcare School Based Team to provide services for my child. I verify, I have read the information regarding the notice of Privacy Practices (HIPAA). _____ (initial)

I give consent for Affinia Healthcare to use and disclose my child's health information to people involved in my child's care, also including my child's regular doctor and school nurse. _____ (initial)
Parent/Legal Guardian Name (print):_____ **Date:** _____
Parent/Legal Guardian (signature): _____ **Date:** _____

Provider Review (signature);_____ Date: _____