COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

School: _____

Teacher Name: _____

Grade: _____

School Based Dental Sealant Program - Parent Permission Form

Questions? Call Community Health Care's Dental Coordinator: 253-210-5294

Community Health Care (CHC) is a non-profit dental care provider selected by Tacoma-Pierce County Health Department to offer convenient, preventive dental services at school. With your permission a registered Dentist **will screen your child, provide oral hygiene education, tooth brushing instructions, and apply sealants and fluoride varnish**. We will notify you of our findings and help refer your child to a dentist if needed. Schedule permitting, we will return within the school year to ensure that the sealants remain intact and to complete another fluoride varnish as appropriate. *This service will not conflict with the regular 6-month check-up your child receives with their family dentist*.

_____ _____ / _____ /_____
Student's Name First Middle Initial Last (if child uses 2 last names, please include both) Student's Birth Date

_____ _____ / _____ /_____ _____
Parent/Guardian First Middle Initial Last Parent's Birth Date Phone

_____
Address City/State/Zip

_____ _____ / _____ /_____
Child's Dentist Name – if applicable Date of last Visit

What is your child's gender? ☐ Male ☐ Female

What is your child's ethnic background? ☐ Hispanic ☐ non-Hispanic

What is your child's race? ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caucasian ☐ Native American ☐ Multi-Racial ☐ Other ☐ Prefer not to Report.

Medical History

Please mark any health conditions your child currently has or has had in the past:

☐ Currently no health concerns ☐ Asthma ☐ Latex Allergy ☐ Other Allergies _____

☐ Epilepsy/Seizures ☐ Diabetes ☐ Heart Problem ☐ Any other health concerns? _____

Please check one of the options and complete the information

CHC will bill insurance, but not you.

☐ **Washington Apple Health/Medicaid:** Please provide child's 9-digit number from the Provider One/Washington State Services Card.
ID # _____ WA

☐ **Private Insurance:** Insurance name: _____

Subscriber Name: _____ DOB: _____ / _____ /_____

Subscriber ID # _____ Group or Policy # _____

Insurance Address: _____ Insurance Phone _____

☐ **None:** My child is not currently covered by any dental insurance. Allow my child to participate through the donated services your program offers. Also, please send me information regarding Washington State Apple Health/Medicaid. *No child turned away due to inability to pay!*

MY CHILD HAS PERMISSION TO RECEIVE AN ORAL HEALTH ASSESSMENT, FLUORIDE VARNISH, AND/OR DENTAL SEALANTS DURING THIS SCHOOL YEAR. "I authorize my child's School District to release my child to Community Health Care staff during the school day(s) identified above, for the performance of any of the dental services herein identified, and further authorize my child's school district to provide this consent form to the Tacoma-Pierce County Health Department and Community Health Care."

_____ _____ / _____ /_____
Parent/Guardian Signature (Required) Date

Community Health Care adheres to all Health Insurance Portability and Accountability Act 1996 (HIPAA) standards. We are committed to protecting the privacy of your child's health information. The HIPAA requires all health care records to be kept confidential. By signing above, we have your permission to communicate with your child's school district's health staff regarding your child's dental needs and health care information.

FOR OFFICE USE ONLY
Dentist Signature_____ Date _____ / _____ /_____

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Application For Sliding Fee

In order to meet the requirements of our Federal Grant, we must collect income information on all patients. In order to qualify for sliding fee payments (for uninsured patients and those whose insurance may not pay for all services), <u>you must fill out the information below</u>.

How many people are supported by this income?_____

Use the number of persons in your family who live in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents. Please list the people you have included:

NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU
_____		_____	
_____		_____	
_____		_____	

How much MONTHLY gross income in your household comes from:

Employment	_____	Disability	_____
Unemployment	_____	Pension Funds	_____
Social Security	_____	VA Benefits	_____
Spousal Support	_____	Public Assistance	_____
Scholarship/Grants	_____	Housing Allowance	_____
Military Family Allotments	_____	Other	_____

TOTAL MONTHLY INCOME **$** _____

To the best of my knowledge, the information given is true and correct. I give Community Health Care permission to verify information about my financial status.

_____	_____	_____
Patient or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date
_____	_____	_____
Patient or Parent/Guardian DOB	Staff member signature	Date

☐ I refuse to disclose my income at this time. I that understand by doing so, I do not qualify for any discounts, even if my insurance refuses to pay.

_____	_____	_____
Patient or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date
_____	_____	_____
Patient or Parent/Guardian DOB	Staff member signature	Date

For Office Use Only:

Annual Income $ _____ # in Household _____ Sliding Scale Level _____ Initials _____