

Child's Name: _____ Date of Birth: _____ Social Security Number: _____

Teacher/Grade: _____ / _____ School: _____
 (Teacher) (Grade)

Please answer Yes or No for each of the services you wish for your child to receive or not receive.

Services are covered by Medicaid and Child Health Plus every 6 months.

Please return to your child's teacher as soon as possible, we are at the school for a limited time.

	Yes	No
I would like my child to receive a dental cleaning, fluoride treatment, toothbrush/floss, and homecare instructions.		
↳ For children ages 6 and younger – fluoride treatment applied every 3 months		
I would like my child to receive a dental exam by the pediatric dentist.		
I would like my child to have dental sealants if needed.		
I would like my child to receive a free dental screening and homecare instructions.		
My child currently has a dentist. (If yes) Name: _____ Phone #: _____		
I DO NOT wish for my child to participate in the program.		
Parent/Guardian Signature: _____		

In order to treat your child we need the following information and your signature.

I consent to having my child receive dental care by the Rushville Health Center dental staff at school. My child may receive above dental services indicated. I consent for the Health Center's Billing Department to apply for dental insurance benefits from my child's insurance carrier if so noted. *If your child has had a dental cleaning within the past 6 months, and you have used your insurance, you are not eligible for insurance reimbursement at this time.* If your insurance covers partial payment or denies services, you are financially responsible for the visit. I consent to having my child's doctor release my child's medical information to the dental staff if my child's health history indicates health problems which may affect his/her dental treatment. If a dentist is noted above, I give permission to forward any dental findings/treatment to them. The Rushville Health Center is in compliance with the Health Information Portability and Accountability Act - HIPAA, which protects and secures the privacy of your Protected Health Information. I understand that I may contact the Rushville Health Center to have a copy of this act sent to me.

 Print Name of parent/guardian (relationship to child) Signature _____ / _____
 (Parent/guardian must sign if patient is under 18 years of age) Date

Parents Date of Birth _____ Social Security Number _____ (These are for registration purposes)

Address _____ Zip Code _____

Home or Cell Phone () _____ - _____ Work Phone () _____ - _____ Email _____

Please complete the dental insurance information below. If your child does not have dental insurance you may qualify for a discount, please request a sliding fee application if needed from the health office.

<p style="text-align: center;"><u>Child Health Plus</u></p> <p>Subscriber ID#: _____ Subscriber Name: _____</p>	<p style="text-align: center;"><u>Blue Cross/Blue Shield</u></p> <p>Subscriber ID#: _____ BC Plan: _____ BS Plan: _____ Insurance address if not Rochester: _____</p>
<p style="text-align: center;"><u>Medicaid</u></p> <p>ID Number: _____ Subscriber Name: _____ Sex (M or F): _____ Birth date: ____/____/____ SEQ#: _____</p>	<p style="text-align: center;"><u>Other Dental Insurance</u></p> <p>Name of dental insurance: _____ Subscriber Id#: _____ Group #: _____ Insurance Phone #: _____ Insurance address: _____</p>

No Dental Insurance

My child does not have dental insurance or qualify for a discount. Please enclose a check made out to: RPCN. A dental cleaning is \$73.00 if your child is 12 years old or younger, or \$90.00 if your child is 13 years old or older. A new patient dental exam is \$48.00. An existing patient dental exam \$28.00.

Check #: _____ Amount Paid: \$ _____

After a dental visit, a report will be sent home and /or we will phone you regarding any concerns.

