Child's Name: ________________________ Teacher/Grade: ________________ / ______
(teacher) (grade)

Please check one, and return to your child's teacher as soon as possible.

_____Yes, I want my child to receive a free dental screening only and send home a report.
(This does not take the place of the yearly dental exam with the dentist.)

_____No, I do not wish for my child to participate in any part of the dental program.

Parent/Guardian Signature________________________________

_____Yes, I would like my child to receive a dental screening, dental cleaning, fluoride treatment, toothbrush and floss.
Please complete pages 2 and 3.

_____My child does not have the dental insurance listed below. I have enclosed a check payable to the Rushville Health Center for $56.70. ______Yes, please send home a receipt with my child so I may submit it to my private insurance.

_____Yes, I would like my child to participate in the dental program and again in six months if available. My child's insurance information is completed below (Child Health Plus, Blue Cross/Blue Shield or Medicaid).
No payment is necessary.

_____Yes, I give permission for my child to have dental sealants if needed.

Child Health Plan

Subscriber Identification Number: |_|_|_|_|_|_|_|_|_|_|

Subscriber Name: ________________

BC Plan ________________ BS Plan ________

Customer Service 1-800-650-4359
When your doctor's office is closed call 1-800-716-4885
This coverage requires annual recertification

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
BENEFIT IDENTIFICATION CARD

ID NUMBER: |_|_|_|_|_|_|_|_|
NAME: ________________
SEX (M OR F) ________
BIRTHDATE: ________________

ISO #	ACCESS NUMBER	SEQ #
____	________	____

Dental Care Program

Subscriber Identification Number: |_|_|_|_|_|_|_|_|_|_|_|_|_|- ___

Subscriber Name: ________________

BC PLAN ________________ **BS PLAN** ________

Customer Service 1-800-724-1675
TTY 585-454-2845
EXPRESSLINE 585-454-5010 1-800-548-6428

Insurance address if not Rochester:
____

**** We are unable to treat your child without complete information and your signature on both pages 2 & 3.***

I consent to having my child receive dental care by the Rushville Health Center dental staff at school. If my child has Child Health Plus, Blue Cross Blue Shield of Rochester Area, or Medicaid. I consent for the Health Center's Billing Department to apply for dental insurance benefits from my child's insurance carrier. 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 child's insurance covers partial payment or denies services you will be financially responsible for the visit. I consent to having my child's doctor release medical information to the dental staff, if my child's health history shows health problems which may affect his/her dental treatment. The Rushville Health Center is in compliance with the Health Information Privacy Protection Act. 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

________________________ Signature (Parent/guardian must sign if patient is under 18 years of age) ____/____ Date

Address ________________________________ ________ Zip Code

Home Phone ( ) _____ - ________ Work Phone ( ) _____ - ________