TOGETHER FOR HEALTH DENTAL CENTER

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

A Clinical Affiliate of Wayne Memorial Health System, Inc.

School Based Dental Program – satisfies the mandated dental screening for students in kindergarten, 3rd or 7th grade

Students Name	Birth Date	☐ Male ☐ Female	
Address	City	State	Zip
School: ☐ Primary ☐ Elementary ☐ Middle ☐ High School	Teacher	Grade	
Parent/Guardian Name	Phone		
Email	Alt. Phone		

IMPORTANT HEALTH QUESTIONS:

Does your child have any **serious health conditions** or has he/she been under the long-term care of a health care provider? **YES or NO** If YES, please explain:

Have you or your child ever been advised by a dentist or a health care provider to have your child **take antibiotics before dental treatment**? **YES or NO**

Does your child take any **daily medications**? **YES or NO** If YES, please explain:

Is your child **allergic to any medications**: **YES or NO** If YES, please explain:

If your child has Medicaid/PA Chip Dental Insurance Information: circle one below
GHP Family **Health Partner Plans** **AmeriHealth** **UMPC** **CHIP** **PA Medical Assistance**
Dental Insurance ID #:_____ Other_____

Private Dental Insurance:
Insurance Company Name:_____**Member ID #**:_____
Insured Adult Name:_____**Insured Adult Birth Date**:_____/_____/_____
Group #:_____Ins. Phone #:_____**Insured Adult SS #:**_____

If Child Has NO Dental Insurance:
Reduced Fees: ☐ Yes, I would like to be contacted about the sliding fee program.
☐ No, I would not like to be contacted about the sliding fee program.

AUTHORIZATION FOR PAYMENT OF SERVICES

I, the undersigned, hereby grant permission to release my dental information and to authorize payment of dental insurance benefits to Wayne Memorial Community Health Centers. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that I am fully responsible for payment of all deductibles, co-insurances and co-pays.

I understand that my signature gives consent for the hygienist to provide dental services for my child and to communicate with my child's primary dental care provider. I give permission to call my home, leave a message on a machine or with a person regarding health care information, and may also mail dental care information to my home. I understand that my child's dental information will be used for treatment and health care operations.

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Parent/Guardian Signature **Printed Name** **Date**

I understand and authorize Wayne Memorial Community Health Centers, its affiliated dentists or dental hygienists, to provide dental services at school to the above named child for whom I am the custodial parent or legal guardian. Services may include: dental cleaning, fluoride treatment, dental x-rays, sealants and if needed, a referral to your family dentist for dental evaluation, treatment or emergency care. This hygiene service does not include an examination by a dentist. This does satisfy the mandated dental screening for students in kindergarten, 3rd or 7th grade.

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Parent/Guardian Signature **Printed Name** **Date**