Office Only:
MRN#_____

School Dental Program

LAKESHORE community health care

Child's First Name: _____ **Last Name:** _____ **Date:** _____

Please complete the consent form below. Thank you.

Section 1:

Is your child presently being seen by a dentist? ☐ Yes* ☐ No **If you currently have a dentist, please continue care with them.*

Is your child currently a patient at Lakeshore Community Health Care? ☐ Yes ☐ No

☐ STOP **No, I do not give permission for my child to participate in the school dental program.** **We welcome all patients. If you have already established care with another provider, we ask that you continue your care with them.*

☐ GO **Yes, I give permission for my child to participate in the school dental program.** I hereby authorize Forward Health or my insurance company to be issued a claim for billable services.

Print parent/guardian name:_____ **Date of Birth:**_____ **Relationship to child:**_____

If you have selected "GO" above, please provide complete information for Section 2 - Section 5.
Please fully complete these sections and sign on the back to prevent a delay in service.

Section 2:

Grade:_____

Child's Date of Birth:_____

School: _____

Home Address: _____

_____
City, State and Zip

Preferred Communication: ___Call ___Text* ___Email
(List: 1,2,3)

Phone to Call: _____

Phone to Text: _____

Email:_____

**Standard text messaging rates may apply.*

Section 3:

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian
☐ Black/African American
☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race

Ethnicity: Hispanic/Latino ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No

Language best served in:_____

Section 4: What type of DENTAL insurance covers your child's dental services?

**No student will be refused services based on their insurance coverage.*

☐ **Forward Health/Medicaid/BadgerCare** Member ID #:_____

☐ **Private Insurance** (i.e. Delta Dental of WI, Anthem Dental, etc.)

Insurance Name: _____ *Member ID/Policy #:*_____

*Policy Holder Name:*_____ *Policy Holder Date of Birth:*_____

Group #: _____ *Insurance Company Phone:*_____

Claim Mailing Address: _____

☐ **No Insurance:** *Uninsured patients will be asked to pay a flat co-payment based on household size and earnings.*

Total # of family members in household _____ **Total household earnings GROSS** (before taxes) _____
☐ Monthly ☐ Yearly

Section 5: Please complete the Student Medical History Form on the back side of this page.

It may be necessary for a LCHC representative to contact you prior to your child's exam.
Please respond back to us to ensure that your child will be seen while we are at their school.

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Section 5: Please fully complete the following questions.

Name of Medical Physician: _____ Date of last exam: _____

Medical Physician's phone: _____ Weight: _____

Name of Medical Insurance: _____ Height: _____

Yes ☐ No ☐ Does your child take any medications? If yes, please list them:

_____

Yes ☐ No ☐ Does your child have any allergies? If yes, please explain:

_____

Yes ☐ No ☐ Has your child ever had any serious illnesses or operations? If yes, please explain:

_____

Yes ☐ No ☐ Has your child ever taken a pre-medication (antibiotic) before a dental visit? If yes, please explain:

_____

Please explain: type of diseases, date of diagnosis, etc.

Yes ☐ No ☐ Down Syndrome: _____

Yes ☐ No ☐ Cerebral Palsy: _____

Yes ☐ No ☐ Autism: _____

Yes ☐ No ☐ Mental Disability: _____

Yes ☐ No ☐ ADD/ADHD: _____

Yes ☐ No ☐ Muscular Dystrophy: _____

Yes ☐ No ☐ Asthma: _____ Inhaler in their possession at school? ☐ YES ☐ NO

Yes ☐ No ☐ Anemia/Sickle Cell: _____

Yes ☐ No ☐ Heart Condition: _____

Yes ☐ No ☐ Rheumatic Fever: _____

Yes ☐ No ☐ Cancer: _____

Yes ☐ No ☐ Thyroid: _____

Yes ☐ No ☐ Liver Disease: _____

Yes ☐ No ☐ Kidney Disease: _____

Yes ☐ No ☐ Tuberculosis: _____

Yes ☐ No ☐ Parasites: _____

Yes ☐ No ☐ Epilepsy: _____ Date of last seizure: _____

Yes ☐ No ☐ Diabetes: _____

Yes ☐ No ☐ Skin Disorder: _____ Please list type/variety: _____

Yes ☐ No ☐ Pregnancy: _____ How many weeks: _____

Yes ☐ No ☐ Hepatitis: _____

Yes ☐ No ☐ Herpes: _____

Yes ☐ No ☐ HIV/AIDS: _____

Yes ☐ No ☐ STD: _____

Any other medical concerns:

I agree to have LCHC contact my medical physician to release medical information pertaining to my child's dental needs. I agree to the sharing of information between my child's school and the LCHC dental program.

Parent or Guardian's Signature: _____ **Date:** _____

This form is good for one year from signed date.