Community Clinic

School Based Health Center Consent Form for Dental Services

Student / Patient Name_____**Date of Birth**_____**Grade**_____

Consent to Treat- School Based Health Center
I understand that the School Based Health Center can provide dental services to my child directly. One consent form per child must be signed and on file for the student to receive services.

Available services may include: dental x-rays, dental cleanings, dental sealants, fluoride treatment and a caries risk assessment

By signing below, I hereby voluntarily consent to dental services (if available and requested), including but not limited to, taking of dental x-rays, routine cleaning, dental sealants, fluoride treatment.

Regarding release of information: (a) I authorize the clinic to release dental, information to the third-party insurance carriers for the purposes of filing insurance claims related to my (his/her) care.
(b) I further authorize the release of dental information to federal and state governing entities for the purposes of required reporting. (c) I further authorize the exchange of dental information to the school as needed for continuity of care and required reporting.

I **agree that my insurance company, if** I **have coverage, can be billed for services rendered, and that any remaining co-pays, deductibles, and/or coinsurance may be billed to me directly.** I **further understand that no person is turned away due to inability to pay.**

*I understand that the Notice of Privacy Practices document has been provided to me.

Dental Services:

1. Has the child/adult had dental care in the past 12 months? Yes____ No ____
2. Does the child/adult have an appointment scheduled at the dental home where care is normally provided? Yes____ No _____
   a. If yes, please list the name and address of the dentist or dental home where the care is provided.
      _____
   b. If yes, we recommend maintaining your relationship within a dental home and not receive services in a SBHC setting
3. "I understand that I can choose to have dental hygiene services provided at the dental home where care is normally provided rather than a SBHC setting. I understand that all dental hygiene care provided by the dental home I have used in the past or a collaborative care dental hygienist will reduce future benefits that the child/adult may receive from private insurance, Medicaid (ARKids) or third party provider of dental hygiene benefits for the remaining benefit period"

Consent for Dental Services:

By signing below, I hereby voluntarily consent to dental services including but not limited to, taking of dental x-rays, routine cleaning, dental sealants, and fluoride treatment. I further consent to the performance of those diagnostic procedures, examinations and rendering of treatment by the dental staff, including dental hygienists as is necessary per provider judgment.

Collaborating DDS: Dr. Christopher Williams Ar. Lic. #4179 **Collaborating RDH:** Annel Ramos Ar. Lic. #3179

_____ _____ _____

Parent/Guardian Signature_____ **Relationship**_____**Date**_____