



**FORM B**

CHART # \_\_\_\_\_  
CODE # \_\_\_\_\_

**General Information (Please Print)**

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Middle Initial Last M/D/Y

Address: \_\_\_\_\_  
Street City State Zip Code

Parent/Guardian Name: \_\_\_\_\_

School Name: \_\_\_\_\_ Home/Contact phone: \_\_\_\_\_

Grade: \_\_\_\_\_ Room# \_\_\_\_\_ Teacher Name \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Race/Ethnicity: Check all that apply American Indian/Alaskan Native Asian Black White  
Native Hawaiian/Pacific Islander Hispanic/Latino

**Health Information**

- Yes No Does your child have a serious health problem? If so please explain: \_\_\_\_\_
- Yes No Does your child have asthma? \_\_\_\_\_
- Yes No Has your child ever had rheumatic fever or rheumatic heart disease? \_\_\_\_\_
- Yes No Has your child ever been diagnosed with a heart murmur? \_\_\_\_\_
- Yes No Is your child presently taking medication? If so please list: \_\_\_\_\_
- Yes No Have you ever been told by a dentist or physician that your child needs to take antibiotics (Penicillin) before dental care? \_\_\_\_\_
- Yes No Is your child allergic to any medications? If so please list: \_\_\_\_\_
- Yes No Is your child allergic to latex? \_\_\_\_\_
- Yes No Has your child ever been examined by a dentist? If so, date of last exam: \_\_\_\_\_  
What was the reason for the visit? \_\_\_\_\_
- Yes No During the last 12 months, was there a time when your child needed dental care and was unable to receive dental services?  
If yes, please explain why. \_\_\_\_\_

Name of your regular dentist: \_\_\_\_\_

**Complete back side of form**

**Consent for Treatment: Signature Required**

**To participate in this program, your child must qualify for HealthWave, Medicaid,  
and/or free and reduced lunches.**

I give "Future Smiles" and the Flint Hills Community Health Center (FHCHC) permission to provide preventive dental services for my child, to collect payment from Medicaid, Health Wave or my private insurance on my behalf and to allow the dentist of my choice to obtain my child's dental record from the evaluation. Treatment may include dental evaluation, oral photos, prophylaxis (cleaning), fluoride varnish treatment, ToothPrints, and/or dental sealants. By signing below, I am indicating that I have read and understand the contents of the cover letter (Form A) accompanying this consent form, that I understand the terms of the consent agreement, that I have the legal authority to give this consent for the child, and that I have received a copy of the Flint Hills Community Health Center's Notice of Privacy Practice. This consent is valid for 24 months.

Please mark the box next to any item that you **DO NOT** want your child to receive and **return this form within 3 days.**

Oral Evaluation	Fluoride Varnish	ToothPrints
Oral Photos (not x-rays)	Dental Sealants	
Oral Prophylaxis (cleaning)	Random re-evaluation in one year	

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Information**

**Medicaid Information**

Child's 12 digit Medicaid recipient ID \_\_\_\_\_

Head of Household Name: \_\_\_\_\_

**Health Wave Information**

Child's Identification Number \_\_\_\_\_

Head of Household Name \_\_\_\_\_

**Other Insurance:** Name of Insurance Company \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

\_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_

Insurance Number \_\_\_\_\_

**I am requesting information about Medicaid/ Health Wave, free or reduced dental and medical insurance for eligible children.**