Mercer County Dental Program Permission Form

Name of School: _____Teacher: _____

Grade: _____ County: _____

Dear Parent or Guardian,
Mercer County Health Department has arranged for dental services for all children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists and assistants will come to your child's school on a mobile dental unit. **In order for your child to receive these services you must provide ALL the information requested below and sign in the area indicated.**

Your Child's Name: _____ Age: _____ Gender: M F

Birth Date: _____/_____/_____ Home Phone: _____

Mailing Address: _____ City/Zip: _____

Does your child qualify for free or reduced meals: YES NO

# of family members: _____ Income per year (optional): _____

Is your child enrolled in the "All Kids" Program: YES NO

Does your child have a Medicaid card YES NO

If yes, include your child's recipient ID number: ___ ___ ___ ___ ___ ___ ___ ___ ___
9 digit # on card

Has your child had any history of, or conditions related to, any of the following:

___ Anemia	___ Chicken Pox	___ Hearing	___ Liver	___ Sickle Cell
___ Arthritis	___ Chronic Sinusitis	___ Heart	___ Measles	___ Thyroid
___ Asthma	___ Diabetes	___ Hepatitis	___ Mononucleosis	___ Tobacco/drug use
___ Bladder	___ Ear Aches	___ HIV/AIDS	___ Mumps	___ Tuberculosis
___ Bones/ Joints	___ Epilepsy	___ Immunization	___ Pregnancy (teens)	___ Venereal disease
___ Cancer	___ Fainting	___ Kidney	___ Rheumatic Fever	___ Other _____
___ Cerebral Palsy	___ Growth Problems	___ Latex Allergy	___ Seizures	

Is your child taking any over the counter medications at this time? YES NO

If yes, please list: _____

Does your child have speech difficulties? YES NO

Has your child ever suffered injuries to the mouth, head or teeth? YES NO

What type of water does your child drink? ____ City ___ Well ___ Bottled ___ Filtered

Important: Parent/guardian signature required

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/school representative and dental provider access to the child's dental record.

Signature: _____ Date: _____

In signing this form, you give permission to treat your child and also verify that you have read the additional form regarding HIPAA. This will also give permission for HFS, QA Audits and providers to return to your school and re-check your child's sealants.

Over →

Dentist's Initials _____

Privacy Practice Acknowledgment

- I am aware that Mercer County Health Department has a HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices.

- I may request a copy at any time by contacting Mercer County Health Department.

Agreement to Pay for Services

- I authorize Eagle View to release my medical information necessary to Medicaid to process claims and further authorize payment of medical benefits payable directly to Mercer County Health Department.

    - I understand that I am responsible for any account balance that is not covered.

My signature indicates that I am giving consent for my child to receive mobile dental services (dental exam, fluoride treatment and sealants) and that I understand the above payment information.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Mailing Address City, State, Zip

_____

Home Phone

Please call 1-309-582-3759 for any questions.