COMPLETE & SIGN ONLY IF YOU WANT YOUR CHILD TO RECEIVE SERVICES AT SCHOOL

Health Promotion Specialists -- School-Based Dental Prevention Program

Student Information

Student Name: _____, _____ **Date:** ____/____/____
Last Name *First Name* *Middle*

☐Male ☐ Female **Student's Birth Date:** ____/____/____ **Social Security # -** _____ - _____ - _____

Preferred Phone #(_____**)**_____ **Email** _____

Home Room Teacher: _____ **Grade:** _____ **School:** _____

Student's Home Address: _____
Street *Apartment #*

_____ Name **of school attended last year:** _____
City *State* *Zip*

Medical Questions
ALL QUESTIONS MUST BE ANSWERED

Child's Dentist:	**Date of child's last teeth cleaning:** ____/____/____	
Child's Doctor:	**YES**	**NO**
Does your child have allergies (including Food, Medicines and/or Latex)? If yes please list:		
Has your child ever had an artificial joint replacement?		
Has your child ever been diagnosed with rheumatic fever?		
Does your child have sickle cell anemia or sickle cell trait? If yes, circle which one.		
List any other serious health problem(s) your child has now.		
List any medications, over the counter medicines, or herbal supplements your child is taking at this time.		

Payment Information – You MUST check and complete A. B. OR C and sign at bottom

A. ☐ **MEDICAID ID** | | | | | | | | | | | *(CHILD'S 10 digit individual #- NOT plan #)*

B ☐ Dental Insurance – If your child has insurance and Medicaid, fill out A & B

Name of Parent or Guardian Who Has Insurance: _____
Home Address: _____
Employee Social Security#_____-_____-_____ **Employee Birth Date:** _____/_____/_____
Insurance ID # _____ **Group #**_____
Name of Company Insured Person Works for: _____
Dental Insurance Company Name and Address: _____
Dental Insurance Co. Phone #: (_____**)**_____

C. ☐ I am responsible for payment. My child has no Medicaid or Dental Insurance.

Teeth Cleaning --Age 11 & Under -$40.00; Age 12 & older -- $54.00 Fluoride Varnish - $26.00
Sealants -$29 per tooth Only on permanent back teeth

I request and authorize HPS, their contracting dentists, and staff, duly licensed as Doctors of Dentistry or licensed dental hygienists, to perform any diagnostic procedures, preventive procedures or treatment procedures on my child. I understand that preventive services do not take the place of an examination by a licensed dentist. I understand that photos may be taken for educational purposes. I further understand that if my child is not enrolled in Medicaid, I am financially responsible to HPS for services performed. I authorize payment of Medicaid or Insurance benefits directly to HPS and their partner dentists. I request and authorize the release of any information on this form or acquired in the course of treatment for payment, referral purposes, and to all appropriate school personnel and SC ORS and SC DHEC, as deemed necessary by HPS.

_____ _____
***Parent/Guardian Signature* (MUST BE SIGNED)** **Printed Name**

RELATIONSHIP To Child_____ **Date**_____