

# Gateway Oral Health Program

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Brooke Jones PHRDH, BSDH | Dir. Of School Oral Health



## CONSENT FOR DENTAL TREATMENT



Gateway District Health Department

Bath, Elliott, Menifee, Morgan, and Rowan

P.O. Box 555 - Gudgeall Avenue • Oxingsville, KY 40360  
(606) 674-6368 • Fax: (606) 674-3071

**Please Print all information on this form if you wish to participate & return it with registration forms for the school year.**  
**Do Not return if you do not wish to participate.**

Child's Name: Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_ Circle: Male/Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Child's Social Security Number (required): \_\_\_\_\_ Race: \_\_\_\_\_ Hispanic/Latino: Y N  
Home Phone #:(\_\_\_\_) \_\_\_\_\_ Mobile #: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Utilized for connection of resources: #in Household: \_\_\_\_\_ Annual Income: \_\_\_\_\_  
Parent/Legal Guardian: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_  
Emergency Contact & phone #: \_\_\_\_\_

### DENTAL HISTORY

Dentist: \_\_\_\_\_ Last Visit: \_\_\_\_\_ Seen dentist every 6 months: Y N  
Do you have trouble finding a dentist or need help locating a dental home? Y N Transportation issues getting to appointment offices? Y N

### MEDICAL INFORMATION

Has your child ever had any of the following (if yes, please explain below):

- |                                                             |                                       |                                                     |
|-------------------------------------------------------------|---------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Surgery- please provide info& date | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Hearing Loss/Speech Issues |
| <input type="checkbox"/> Bleeding Problems                  | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Problems             |
| <input type="checkbox"/> Seizures/Epilepsy                  | <input type="checkbox"/> Autism       | <input type="checkbox"/> ADD/ADHD                   |
| <input type="checkbox"/> Cancer/Chemo                       | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Antibiotic premedication   |
| <input type="checkbox"/> Trauma (head, neck, mouth)         | <input type="checkbox"/> Anxiety/Fear | <input type="checkbox"/> OTHER:                     |

If yes, explain: \_\_\_\_\_

Allergies: \_\_\_\_\_

Daily Medication: \_\_\_\_\_

Circle all that apply: No Insurance Private Dental Insurance Medicaid

Medicaid Number \_\_\_\_\_ MCO Number \_\_\_\_\_

**CIRCLE MCO:** UNKNOWN AETNA ANTHEM HUMANA CARESOURCE PASSPORT WELLCARE MOLINA UNITED HEALTHCARE

**\*\*\*This service is provided to your child whether you have insurance, so do not worry. Medicaid Medical Provisions will be billed, but those without insurance or with private dental insurance are not billed. This program does not affect your dental insurance benefits or your local dental homes!!**

**CONSENT FOR DENTAL SERVICES and ASSIGNMENT OF BENEFITS:** I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care for my child which may include dental screening/assessments, preventative dental treatment, and any other health service provided by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any preventive service provided for my child. I also understand that no x-rays will be taken and that my child may be screened to check the retention of these sealants by the public health dental hygienist the following school year. I also understand that my child may be tested for HIV, Hepatitis B, or any other bloodborne disease should a healthcare worker be exposed to blood or bodily fluids. I authorize this health department to release dental information about my child, as permitted by HIPAA to his/her primary care physician, dentist, and school staff. I authorize the release of my child's dental records to a dentist for follow-up care and establishing a dental home. This program does not take the place of regular check-ups at a dental office. The services are being provided by a Public Health Registered Dental Hygienist. I understand that no dentist is present or required for the PHRDH to perform the dental procedures according to the KRS 313.040 KY Dental Practice Act. **PRIVACY:** This form, when completed and signed, contains Protected Health Information which will be protected according to the Health Insurance Portability and Accountability Act (HIPAA). My signature below acknowledges my understanding of Gateway District Health Department (GDHD) "NOTICE OF PRIVACY PRACTICES" \*\*\* and how to receive a copy on the date stated. I have read the above and I understand the items included in this packet as they apply to me and my child. Text messaging may be utilized. Text may contain personal health information regarding you and are not considered a confidential means of communication. The signature below indicates I do consent, authorize, and declare as stated above. Permission can be revoked at any time. **ASSIGNMENT OF BENEFITS:** I request that payment of authorized insurance benefits be made to GDHD on my child's behalf, for services received. I also authorize GDHD to release oral health information about my child to Medicaid to determine Payment for services.

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Legal Guardian Signature

(Expires at end of the school year)

**DO NOT SIGN FORM OR RETURN IF YOU DO NOT WISH TO PARTICIPATE.**

\*\*\* You can request a physical copy of our HIPAA form, view online by visiting [GDHD.org](http://GDHD.org), or request an emailed copy.

"Sparkling Futures Start with A Sparkling Smile"



# Gateway Oral Health Program

## Dental Care for Children at School

**A preventative dental program provided by the Gateway District Health Department and a Public Health Registered Dental Hygienist with no-out-of-pocket expense! Your child's dental benefits remain unused and will not affect your visit with a dentist!**

We are supported by the Dept of Public Health, KY Dental Director, GDHD Health Board, along with members of the local dental and healthcare community. Using state funds, grant money and Medicaid Medical Provisions allow us to provide these services to all kids for free.

The **BEST** way to protect children from tooth decay is to **STOP** it before it starts. Regular dental assessments, cleanings, sealants, and fluoride are essential to building strong, healthy, beautiful teeth for a lifetime.

Our GDHD **Public Health Registered Dental Hygienist (PHRDH)**: will visually screen your child's teeth, provide an age-appropriate dental cleaning (oral health education/nutrition /tobacco education included), dental sealants as needed, and apply fluoride varnish.

**Fluoride:** Fluoride Varnish is a layer of fluoride that is painted onto the teeth. It can be applied up to six times a year. Fluoride can prevent, slow down, and reverse the tooth decay process.

**Dental Sealants:** Sealants are applied in the grooves of molars to prevent cavities in the chewing surfaces of your child's teeth. They can last up to 10 years. They save lots of time and money in preventing extensive dental work.

A licensed dentist will not be present during the screening, nor required for the PHRDH to give this service (KY Dental Practice act KRS 313.040).

Each child will receive a toothbrush, toothpaste, and a dental report card. If dental problems are noted, a referral to a dentist will be made along with support and resources from our program.

***Only a licensed dentist may make a diagnosis of decay, PHRDH will refer for decay and support the patient/parent, and established dentist as needed.***

**Please complete the back of this form to allow your child to participate.**

For questions, contact: Brooke Jones PHRDH, BSDH- Director Gateway Oral Health Program

Email: [brookel.jones@ky.gov](mailto:brookel.jones@ky.gov) Phone: (606) 784-8954 ext. 3140