SCHOOL BASED DENTAL CARE
PATIENT INFORMATION and CONSENT FORM

Missouri Ozarks Community Health will provide dental services at your child's school during school hours. Your child's participation is voluntary. In order for them to receive dental services you will need to complete this form and return it to the school. Please contact your school nurse or Missouri Ozarks Community Health if you have any questions.
PLEASE COMPLETE USING BLUE OR BLACK INK

PATIENT INFORMATION:

Patient's Name:_____

Name patient wishes to be called:_____

Date of Birth:_____/_____/_____ **Patient's age:** _____ **Sex:** _____

Grade:_____ **Homeroom Teacher:** _____**School patient attends:**_____

Parent/Legal Guardian Name:_____

Home address (mailing):_____

City:_____ **State:** _____ **Zip:** _____

Telephone numbers: Home:_____ **Cell:**_____
Work:_____ **(Please circle best # to call during school hours)**

Preferred Pharmacy:_____

Medicaid/ MOHealthNet: YES _____ **NO** _____
ID Number: _____

Private dental insurance: YES _____ **NO** _____
Insurance Company name:_____ **Ins. Phone:**_____
Name of Insured Adult:_____ **DOB of Insured:**_____
Member/Policy #:_____ **Group #:**_____

Is your child eligible for free/reduced school lunches? YES _____ **NO** _____

Has your child seen a dentist before? YES____ **NO**_____
Date of last dental visit:_____
If yes, treatment received: _____

Please check the reason(s) for seeking dental care for you child:

Routine checkup _____	Appearance of teeth ____	First visit _____
Swelling of face _____	Toothache _____	Crowding of teeth _____
Accident to the teeth ____	Bleeding around the teeth____	Other (specify) _____

DENTAL AND MEDICAL HISTORY OF YOUR CHILD: (Please circle YES or NO where indicated)

Has the child had any unusual or unpleasant experiences in a dental or medical office?……..	YES	NO
Has the child ever had any injuries to the face, mouth or teeth?.....	YES	NO
Has the child ever had a toothache? ……...	YES	NO
Does the child have any oral habits such as thumb sucking?.....	YES	NO
Is the child presently in good health?.....	YES	NO
Is the child presently under the care of a physician?.....	YES	NO
Has the child been in a hospital or had surgery?.....	YES	NO
Is the child's immunization record up to date?.....	YES	NO

OVER, PLEASE »

Does your child take any fluoride supplements?..... YES NO
Is the child taking any medications at this time?..... YES NO
If yes, please list:_____
Has the child had any unusual reaction or allergy to medication like
Penicillin, aspirin, or local anesthetics?..... YES NO
If yes, please explain: _____
Does your child have a history of seasonal allergies?..... YES NO
Does your child have a latex allergy?..... YES NO
Does your child have any allergies not listed above? _____ YES NO

Does the patient have a history of:

Abnormal bleeding……	YES	NO	Cerebral Palsy……..	YES	NO
ADD/ADHD……	YES	NO	High blood pressure……	YES	NO
AIDS or HIV……	YES	NO	Kidney problems……	YES	NO
Liver disease……	YES	NO	Convulsions (seizures)/Epilepsy	YES	NO
Rheumatic fever……	YES	NO	Autism ……	YES	NO
Fainting/Dizziness…….	YES	NO	High fevers……	YES	NO
Diabetes……	YES	NO	Tonsillitis……	YES	NO
Tuberculosis (TB)……	YES	NO	Behavioral problems……	YES	NO
Anemia……..	YES	NO	Hepatitis……..	YES	NO
Nutritional problem……	YES	NO	Vision problems……..	YES	NO
Speech problems……	YES	NO			
Hearing problems……	YES	NO			
Birth defects……	YES	NO			

Cancer or tumors……YES NO -----→ *If yes, please explain* _____
Congenital Heart Defect ……....YES NO ------→*If yes, does child require premedication?YES NO*
Asthma……YES NO ------→*If yes, when was last asthma attack?*_____
Do they require an inhaler? YES NO

Any special conditions not listed above?

_____

CONSENT FOR DIAGNOSTIC AND PREVENTIVE TREATMENT AND ASSIGNMENT OF BENEFITS:

I consent for my child to receive preventive dental services in Missouri Ozark Community Health's mobile clinic. Dental preventive services include but are not limited to screenings, exam, x-rays, cleaning, fluoride and sealants. If treatment beyond preventive services is recommended, a separate consent form will be sent home to review prior to any further treatment.
I hereby give consent to the Missouri Ozarks Community Health staff to perform those procedures and treatments, which are deemed necessary with the **exception** of :

Assignment of benefits: I understand that eligible services may be billed to Medicaid and/or private insurance. I hereby instruct and direct all proceeds of insurance to be paid to Missouri Ozarks Community Health to be paid by check for the dental benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for the professional service rendered. I authorize MOCH to release or receive information on eligibility and/or benefit information for the purpose of filing insurance claims. I also understand that additional information may be needed from my file to achieve maximum benefits. I acknowledge receipt of the HIPAA Notice of Privacy Practice attached to this consent form. I understand that this consent may be revoked at any time upon my request.

This treatment consent will be in effect for the year August 1, 2022 through July 31, 2023.

Patient Name:_____

Parent/Legal Guardian Signature:_____ Date_____

Ava (417)683-5739 504 W Broadway , Ava MO
Mansfield (417)924-8809 804 N Highway 5, Mansfield MO
Gainesville (417)679-2775 201 S Elm, Gainesville MO
Cabool (417)962-5422 904 Zimmerman, Cabool MO
Mt. Grove (417)926-1713 1604 C N. Main, Mt. Grove MO
Houston (417)967-0772 1340 Sam Houston Blvd., Houston MO
Licking (573)674-1089 135 College AVE, Licking, MO

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