QUESTIONS?
Call Hope Ziegler
Dental Coordinator
253-722-1551

COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

Bethel School Based Health Center
Dental Service Day

Service Date:
March 30th, 2021

School Based Health Center
Dental Service Day
Parent Permission Form

Community Health Care (CHC) is a *non-profit* dental care provider selected by Tacoma-Pierce County Health Department to offer convenient, preventive dental services at school. *With your permission* a registered Dentist will screen your child, **provide oral hygiene education**, **tooth brushing instructions**, and **apply sealants** and **fluoride varnish**. We will notify you of our findings and help schedule your child for further treatment *if needed*. This service *will not* conflict with the regular 6-month check-up your child receives with their family dentist.

_____ _____/_____/_____
Student's Name First Middle Initial Last (if child uses 2 last names, please include both) Student's Birth Date

_____ _____/____/____ _____
Parent/Guardian's First Middle Initial Last Parent/Guardian's Birth Date Phone/Cell

_____
Address City/State/Zip

_____ _____/_____/_____
Child's Dentist Name - *If applicable* Date of Last Visit

Health History

Please mark *any* health conditions your child currently has or has had in the past:

___Currently no health concerns ___Latex Allergy ___Other Allergies _____ ___Asthma

___Epilepsy/Seizures ___Diabetes ___Heart Problem **Any other health concerns?** _____

Dentist Signature (CHC Use):_____**Date:**_____/_____/____

What is your child's gender? ☐ Male ☐ Female

What is your child's ethnic background? ☐ Hispanic ☐ Non- Hispanic

What is your child's race? ☐ Caucasian ☐ Black/African American ☐ Native American ☐ Asian/Pacific Islander
☐ Multi-Racial ☐ Other_____ ☐ Prefer not to Report

Please check one of the options and complete the information: *CHC will bill insurance, but not you.*

◯ **Washington Apple Health/Medicaid:**_____**WA**
Please provide child's 9 digit number from the **Provider One/Washington State Services Card.**

◯ **Private Insurance:** Subscriber Name:_____DOB:_____/_____/_____
Subscriber ID#:_____Group or Policy #_____Ins. Phone#_____
Insurance name:_____Ins. Address: _____

◯ **None:** My child is not currently covered by any dental insurance, allow my child to participate through the donated services your program offers. Also, please send me information regarding Washington State Apple Health/Medicaid. ***No child turned away due to inability to pay!!!***

MY CHILD HAS PERMISSION TO RECEIVE AN ORAL HEALTH SCREENING, FLUORIDE VARNISH AND DENTAL SEALANTS (IF NEEDED) DURING THIS SERVICE.

_____ _____/_____/_____
Parent/Guardian Signature (Required) Date

Community Health Care adheres to all Health Insurance Portability and Accountability Act 1996 (HIPAA) standards. We are committed to protecting the privacy of your