*Cumberland Family Medical Center, in conjunction with your child’s Family Resource/Youth Services Center, is offering dental screenings at your child’s school! These screenings will be performed by a licensed dentist and may occur twice during the school year. This preventative service includes a visual screening, cleaning, fluoride treatment, x-rays and sealants, if needed. If any dental issues are found, the child will be referred to his/her personal dentist, and a follow-up report will be provided to the parent/guardian. Each participating student will receive a gift pack that includes a new toothbrush and toothpaste. If you would like for your child to participate, please complete* ***both*** *sides of this form and return it to the Family Resource/Youth Services Center at your child’s school.*

**Parent/Guardian Information (Please Print):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_

*First Middle Last*

Address of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street City, State Zip Code*

Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of People in Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual Household Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Information (Please Print):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_

*First Middle Last*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street City, State Zip Code*

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: M / F Race: \_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Does the student have Medical Insurance? Yes / No Name of Medical Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have Dental Insurance? Yes / No Name of Dental Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **NO** medical and/or dental insurance, would you like assistance in obtaining insurance through the Affordable Care Act? Yes / No

**Medical History Information:**

Name of the students primary care physician?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have or has he/she ever had:

Heart Murmur? YES / NO

Diabetes? YES / NO

Seizures? YES / NO

Rheumatic Heart Disease? YES / NO

Bleeding Problems? YES / NO

Congenital Heart Disease? YES / NO

Is the student currently taking any medication? YES / NO Asthma YES/ NO   
If yes, please list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have any allergies? YES / NO  
If yes, please list allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the student been to the dentist before? YES / NO If yes, date of last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of student’s dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else we should know about the **student’s health or about any dental care** he/she has had in the past? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*** COMPLETE BOTH SIDES OF THIS FORM ***

CONSENT OF PARTICIAPTION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

\_\_\_\_\_ ***YES, I give consent for the named student to participate in the dental outreach program. I understand this student may receive cleanings twice during the school year, sealants, and x-rays if needed. I give permission for insurance to be billed, if applicable. I have read and understand the Receipt of Notice of Privacy Practices. I understand it is my responsibility to notify Cumberland Family Medical Center, Inc. (dba: Adair Family Medical Center, Casey Family Medical Center, Clinton Family Medical Center, Cumberland Family Medical Center, Glasgow Pediatric Healthcare, Greensburg Healthcare, Jamestown Family Medical Center, McCreary Family Medical Center, Monroe Family Medical Center, Munfordville Family Medical Center, Russell Family Medical Center, Women’s Care of the Bluegrass/Family Care of the Bluegrass, Wellness on Wheels) regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.***

\_\_\_\_\_ *No, I do not want the above named student to participate in the dental outreach program.**I have read and understand the Receipt of Notice of Privacy Practices.* *I understand it is my responsibility to notify Cumberland Family Medical Center, Inc. (dba: Adair Family Medical Center, Casey Family Medical Center, Clinton Family Medical Center, Cumberland Family Medical Center, Glasgow Pediatric Healthcare, Greensburg Healthcare, Jamestown Family Medical Center, McCreary Family Medical Center, Monroe Family Medical Center, Munfordville Family Medical Center, Russell Family Medical Center, Women’s Care of the Bluegrass/Family Care of the Bluegrass, Wellness on Wheels) regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.*

***If the student is not enrolled in Kentucky Medicaid, you may attach a $10.00 check to pay for the student’s screening. Please make your check***

***payable to Cumberland Family Medical Center, Inc., and please include the student’s name on the check. Thank you.***

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_**

**OFFICIAL USE ONLY** Amount Paid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Cash □ Check / Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL OUTREACH PROGRAM  
*Receipt of Notice of Privacy Practices***

*dba: Adair Family Medical Center, Casey Family Medical Center, Clinton Family Medical Center, Cumberland Family Medical Center, Glasgow Pediatric Healthcare, Greensburg Healthcare, Jamestown Family Medical Center, McCreary Family Medical Center, Monroe Family Medical Center, Munfordville Family Medical Center, Russell Family Medical Center, Women’s Care of the Bluegrass/Family Care of the Bluegrass, Wellness on Wheels*

I understand that as part of my participation in the Dental Outreach Program, health records are originated and maintained. These health records describe my dental history, symptoms, examination and recommendation for future treatment and/or care. I understand this information serves as:

* A basis for planning my care and treatment
* A means of communication among health professionals
* A source of information for applying my medical information
* A means by which a third-party (i.e. Medicaid) can verify that services were actually provided
* A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

Cumberland Family Medical Center, Inc. (dba: *Adair Family Medical Center, Casey Family Medical Center, Clinton Family Medical Center, Cumberland Family Medical Center, Glasgow Pediatric Healthcare, Greensburg Healthcare, Jamestown Family Medical Center, McCreary Family Medical Center, Monroe Family Medical Center, Munfordville Family Medical Center, Russell Family Medical Center, Women’s Care of the Bluegrass/Family Care of the Bluegrass, Wellness on Wheels*) ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The Notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.