Southern West Virginia Health System
Lincoln Primary Care Center Inc.

School Based Health Center Dental Consent Form

If you fill out this consent form, your child will have the following dental services: exam, cleaning, fluoride and/ or x-rays. Parents/guardians will be contacted about your child's appointment. If you have any questions please call (304)688-9949.

Student Name: _____

Gender: ☐ Male ☐ Female **Race:** ☐White ☐Black ☐Hispanic ☐Other _____**Phone:** _____

Address: _____
PO or Street City State Zip

Birthdate: _____ **S.S.N.** _____ **Grade:**_____ **School:**_____

HEALTH INFORMATION

Does your student:
Have any chronic illnesses (Asthma,Diabetes,etc.) _____

Take any medication on a daily basis? If so, please list:_____

Medication/Drug allergies? Any other allergies? _____

PARENT(S) OR LEGAL GUARDIAN(S) AND EMERGENCY CONTACT

Parent or Legal Guardian: _____**Relationship:**_____**Phone:**_____**Work/Cell:** _____

Parent or Legal Guardian: _____**Relationship:**_____**Phone:**_____**Work/Cell:** _____

Emergency Contact: _____ **Relationship:**_____ **Phone:**_____**Work/Cell:** _____

DENTAL INFORMATION

The boxes below must be checked for your child to be seen

How often does your child go to the dentist? _____

When was your child's last dental exam? _____

I would like for my child to have the following dental services:

☐Cleaning/Fluoride/Exam/Sealants/X-rays

☐ Filllings, Extractions, or any other necessary restorative dental treatment

DENTAL INSURANCE INFORMATION

Please complete other side and provide a copy of the insruance card

☐Medicaid ☐ Unicare ☐ Aetna ☐ WV Family Health Child's number: _____

☐ Chips Child's number: _____

☐ Private Dental Insurance

Insurance Company: _____

Phone# : _____ Group # _____

Insured's Employer:_____ Phone#_____

Insured's address (if different from child): _____

Insured parent/guardian: _____

Insured DOB: _____ Isured SSN: _____ ID#_____

Secondary Insurance:

☐Medicaid ☐ Unicare ☐ Aetna ☐ WV Family Health Child's number: _____

☐ Chips Child's number: _____

☐ Private Dental Insurance

Insurance Company: _____

Phone# : _____ Group # _____

Insured's Employer:_____ Phone#_____

Insured's address (if different from child): _____

Insured parent/guardian: _____

Insured DOB: _____ Isured SSN: _____ ID#_____

☐ My child is uninsured and I would like information regarding sliding fee

The services of the health centers are provided in partnership with Lincoln Primary Care Center, Inc. and the local county Board of Education.

I, the parent or guardian, gives consent for treatment of the dental services listed in the packet, while my child is a student of the local county Board of Education. I understand that not all school based health center are billable to all insurance companies and I am responsible for any amount not paid by my insurance. The Health Center may release information regarding treatment to third party payors for billing purposes. By signing this consent form I am giving the SBHC permission to treat my child. Information will only be shared with persons outside of the health center staff with parental or guardian consent. I may withdraw consent at any time by contacting any member of the staff in writing.

Parent/Guardian Name: _____

Signature of Parent/Legal Guardian: _____

Relationship to Patient: _____ Date: _____