Barren River District Health Department
1109 State St. • P.O. Box 1157 • Bowling Green, KY 42102
Ph: (270) 781-8039 • Fax: (270) 796-8946 • www.barrenriverhealth.org

Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Simpson, Warren Counties

CONSENT FOR DENTAL TREATMENT

SITE NAME_____

CHILD'S NAME _____ BIRTHDATE:_____ RACE:_____ HISPANIC ☐Y ☐N

ADDRESS: _____ ☐MALE ☐FEMALE

CHILD'S SOCIAL SECURITY #:_____ HOME PHONE #:_____ WORK/CELL#:_____

EMERGENCY CONTACT NAME: _____ PHONE#_____

Who does the child live with? _____

KY MEDICAID ID # (if applicable):_____ NO. IN HOUSEHOLD:_____

STUDENT'S DOCTOR: _____ DOCTOR'S PHONE #:_____

STUDENT'S DENTIST: _____ DENTIST'S PHONE #:_____

WHEN WAS HIS/HER LAST DENTAL CHECK-UP? _____ DOES YOUR CHILD REGULARLY SEE A DENTIST? _____

WHAT IS THE CHILD'S USUAL SOURCE OF MEDICAL CARE NONE_____ EMERGENCY ROOM____ DOCTOR\CLINIC_____

DOES YOUR CHILD HAVE A HEART CONDITION? If yes, describe_____ HEART MURMUR YES NO

DOES YOUR CHILD REQUIRE PRE-MEDICATION?

DOES THE STUDENT HAVE: ☐ SEIZURES ☐DIABETES ☐CHRONIC ILLNESS _____
(Attach a separate sheet for additional space)

ALLERGIES/ASTHMA (food, insects, medication, other)_____

(If allergies or asthma are listed, please fill out back of sheet)

CURRENT MEDICATIONS: _____

SIGNIFICANT MEDICAL/SOCIAL HISTORY (Including injuries)_____
(Attach a separate sheet for additional space)

CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS (Expires 1 year from date signed)
I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include dental screenings, dental cleanings, x-rays, fluoride treatments, and dental sealants by a dentist and hygienist affiliated with the Barren River District Health Department. The dentist will be present to perform the exam, but may or may not be present during the cleaning, fluoride, x-rays and sealant appointment. If your child has cavities or needs an extraction of a tooth, they may be referred out to a participating dentist with BRDHD. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a healthcare worker is exposed to his/her blood, body fluids or tissue. I authorize the dental clinic to release dental information about my child, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share pertinent dental information (history of allergies or significant dental history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I request that payment of authorized medical insurance benefits be made to Barren River District Health Department on my behalf, for services my child receives. I also authorize the local health department to release dental information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Barren River District Health Department's Privacy Notice.
I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

_____ _____ _____
(Signature of Parent/Guardian) (Printed Name of Parent/Guardian) (Date Signed)