WELCOME TO THE SCHOOL DENTAL PROGRAM

Brought to you by the Department of Community Health a Division of Public Health
If you have any questions call 706-721-5891

SCHOOL NAME:_____ CHILD'S NAME: _____

TEACHER'S NAME:_____ GRADE:_____ ROOM NUMBER_____

We are pleased to offer your child the services of the Georgia Public Heath School Dental Program. Please take a few minutes to fill out this form as completely as possible. If you are not interested in the program please return the blank permission forms. If the form is not filled out completely or signed we will not be able to treat your child.

Please return all of the forms in the envelope that is provided.

PLEASE DO NOT SIGN UP FOR THIS PROGRAM IF YOUR CHILD HAS A REGULAR DENTIST, HAS SEEN ANOTHER DENTIST IN THE LAST 6 MONTHS, OR HAS AN APPOINTMENT WITH ANOTHER DENTIST .

These are the two options to be eligible for our dental program. Please check one of the following:

____ My child has Medicaid, Peachcare, Wellcare, or Amerigroup. There is no co-pay or fee for children who have Medicaid, Peachcare, Wellcare, or Amerigroup. The dental clinic will file claims and receive reimbursement directly from Medicaid, Peachcare, Wellcare, or Amerigroup for dental services.

____ My child DOES NOT have Medicaid, Wellcare, Amerigroup, Peachcare, private insurance, or a regular dentist and I am interested in paying for my child's dental services. Please include $35.00 cash along with the permission forms in the envelope that is provided. The $35.00 fee is per visit. If your child needs an additional visit we will contact you. Please provide the following information for your child to receive treatment.

Total number in family _____
Total family income (monthly) _____.

Child's Name:_____
Last First Middle

Address:_____
Street City Zip County

Home Phone:_____ Cell Phone:_____

SSN#:_____ Medicaid Number(s):_____

Birth Date:____/____/_____ Age: _____ Sex: M / F Race:_____ Hispanic Yes / No

Father's Name:_____Mother's Name:_____

Has your child ever been to the dentist? Please circle one. Yes / No

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MEDICAL HISTORY **CONFIDENTIAL**

YES	*NO*	
☐	☐	**HEART TROUBLE or HEART MURMUR? (CIRCLE ONE) _____**
☐	☐	**HAS YOUR CHILD EVER HAD BATERIAL ENDOCARDITIS?**
☐	☐	**RHEUMATIC FEVER? _____**
☐	☐	**TUBERCULOSIS? _____**
☐	☐	**DIABETES? _____**
☐	☐	**KIDNEY DISEASE? _____**
☐	☐	**LIVER DISEASE? _____**
☐	☐	**HEPATITIS? _____**
☐	☐	**EPILEPSY? IF YES LIST DATE OF LAST SEIZURE:_____**
☐	☐	**MENTAL PROBLEMS? _____**
☐	☐	**PROLONGED BLEEDING? _____**
☐	☐	**BLOOD DISEASE? _____**
☐	☐	**SICKLE CELL TRAIT or DISEASE? (CIRCLE ONE)_____**
☐	☐	**HIV OR AIDS? _____**
☐	☐	**ASTHMA? _____**
☐	☐	**ALLERGIES TO MEDICINE? (EXPLAIN)_____**
☐	☐	**OTHER ALLERGIES? _____**
☐	☐	**ARE YOU UNDER THE CARE OF A PHYSICIAN? (EXPLAIN)_____ _____**
☐	☐	**ARE YOU TAKING ANY MEDICATION? (LIST ALL) PRESCRIPTIONS AND OVER THE COUNTER? _____**
☐	☐	**OTHER SEVERE ILLNESSES? (EXPLAIN)_____**

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The consent statement must be signed for your child to receive treatment.

CONSENT TO TREATMENT

I consent to general dental treatment for my minor child that in the judgment of the dentist is necessary for oral health. This treatment may include but is not limited to the following: preventive services, restoration of teeth, extracting of teeth, x-rays, administration of drugs/local anesthetics, root canals, oral surgery and other specialty treatments deemed necessary.

I approve the release of my records to my Medicaid/Peachcare or other dentists as deemed necessary by the dentist.

I authorize the dentist to file claims and receive reimbursement directly from Medicaid/Peachcare (Amerigroup or Wellcare).

I have received the Notice of Health Information Practices from the County Board of Health.

DATE: _____SIGNATURE: _____

History Verified : Dentist Initials