DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Government of the District of Columbia
School Based Oral Health Program Consent Form

Dear Parent or Guardian:

The District of Columbia Department of Health (DC Health) sponsors preventive dental services at your child's school/facility through the DC School-Based Oral Health Program (SBOHP). Through this program, licensed dentists and their staff provide exams ("checkups") and x-rays to students who have not seen a dentist in six (6) months. The services include dental cleanings, fluoride treatments, and sealants (as needed). Children who may need additional services such as fillings, drillings, shots, tooth removal, or braces, will be referred to their dental homes. Information from your child's visit will be shared with the appropriate point of contact at the school/facility, and with the SBOHP for the purposes of follow-up, and program monitoring.

PLEASE NOTE: Children should see their dentists every six (6) months. The SBOHP services should NOT take the place of a visit to a child's regular dentist. The dental providers will check for dental insurance coverage and the last dental visit for all children to be seen at the school/facility and will bill insurance for any services provided.

CHILD/STUDENT INFORMATION

Child Name: Click or tap here to enter text.

Date of Birth (MM/DD/YY)**:** Click or tap here to enter text. | **Current Gender Identity:** Click or tap here to enter text.

Home Address (Street, City, State, Zip Code)**:**
Click or tap here to enter text.

Ethnicity (check all that apply)**:** ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer

Race (check all that apply)**:** ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Prefer not to answer

School/Facility Name: Click or tap here to enter text. | **Grade:** Click or tap here to enter text.

Teacher Name: Click or tap here to enter text.

Parent/Guardian Name: Click or tap here to enter text.

Phone Number: Click or tap here to enter text. | **Alternate Phone Number:** Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Last Dental Visit: ☐ 1-3 Months ago ☐ 4-6 Months ago ☐ 6+ Months go ☐ Unsure ☐ Never

Primary Dental Provider: Click or tap here to enter text.

HEALTH INSURANCE

You must select one of the checkboxes and provide all related information in order for your child to receive services.

☐ **This child has the following DC Medicaid/ DC Healthy Families insurance plan:**

☐ **AmeriHealth Caritas (ID #:** Click or tap here to enter text.**)**

☐ **Amerigroup (ID #:** Click or tap here to enter text.**)**

☐ **Health Services for Children with Special Needs (HSCSN) Inc. (ID #:** Click or tap here to enter text.**)**

☐ **MedStar Family Choice (ID #:** Click or tap here to enter text.**)**

☐ **Medicaid Fee-For-Service ("Straight Medicaid") (ID #:** Click or tap here to enter text.**)**

☐ **Other**: Click or tap here to enter text.

☐ **This child has private dental insurance:**

Insurance Company: Click or tap here to enter text.

Insurance Co. Phone: Click or tap here to enter text.

Employer: Click or tap here to enter text.

Employer Phone: Click or tap here to enter text.

Name of Insured Adult: Click or tap here to enter text.

Insured Adult's Date of Birth: Click or tap here to enter text.

Member ID/Policy#: Click or tap here to enter text.

Group #: Click or tap here to enter text.

☐ **This child does not have any dental insurance**

Please complete and sign the consent form on the back

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As the parent/guardian of the student, I consent for him/her to receive dental services through the DC Health School-Based Oral Health Program. I understand that my child's participation provides consent for the following:

- The dental provider to verify insurance before services are provided.
- The dental provider to bill & collect payment from any Medicaid, private insurance, or other payer.
- If I have private dental insurance, the dental provider to bill the family for any deductibles and/or copays.
- The dental provider to confidentially share my child's clinical information with DC Health, DC Department of Health Care Finance, Medicaid Managed Care Organizations, and/or other clinical providers involved in my child's health care.

Further, I agree to discharge, indemnify, and hold harmless the Government of the District of Columbia and any agency, employee, officer, agent, or representatives thereof from all claims, demands, actions, or judgments which I or my heirs, executors, administrators, or designees may have for any and all injuries and damages, known or unknown, caused by or arising from the activities listed above. **I understand that if I fail to sign this consent form, my child will not receive any services offered under this program.**

I understand I may revoke this consent at any time by providing written notice to DC Health's Oral Health Program (2201 Shannon Place SE 5th Floor, Washington, DC 20020) or via email doh.oralhealth@dc.gov. I further understand that until this revocation is made, the consent for services shall remain in effect for one calendar year from the date it is signed, and my child's information will continue to be accessible by the parties listed above for the specific purposes described.

Please provide the following information to help the dental provider best serve your child:

MEDICAL INFORMATION **Check each condition that applies to your child and explain in the space provided.**
☐ **Dental problems** Click or tap here to enter text.
☐ **Heart problems/valve replacements/shunts** Click or tap here to enter text.
☐ **Asthma/breathing problems** Click or tap here to enter text.
☐ **Epilepsy/seizures** Click or tap here to enter text.
☐ **Allergies** ☐ Latex allergy ☐ Pine nut allergy ☐ Acrylic allergy ☐ Other Click or tap here to enter text.
☐ **Current medications** Click or tap here to enter text.
☐ **Antibiotics premedication required** Click or tap here to enter text.
☐ **Other health problems (diabetes, bleeding problems, communicable diseases, etc.)** Click or tap here to enter text.
Child's Primary Care Doctor and/or Provider (if applicable): Click or tap here to enter text.

I have read the notice on the back of this page and understand and agree to its terms. By signing, I give my informed consent for my child to receive services through the DC Health School-Based Oral Health Program.

Parent/Guardian Signature: _____ **Date:** _____