KONZA PRAIRIE Community Health Center

Pharmacy
361 Grant Avenue
Junction City, KS 66441
785.579.6146
866.533.3613

LOCATIONS

Junction City
361 Grant Avenue
Junction City, KS 66441
785.238.4711
Medical: 866.309.8893
Dental: 877.671.5661

Manhattan
2030 Tecumseh Road, Suite 100
Manhattan, KS 66502
785.320.7134
Medical: 866.807.7393
Dental: 866.534.5933

SECTION 1 – REGISTRATION

PLEASE FILL OUT COMPLETELY

***STUDENT INFORMATION:**

First Name
Last Name

SSN _____ Grade _____ DOB _____ Age _____ Gender: ☐ Male ☐ Female
School _____ City/State _____ Teacher _____

***PLEASE CHECK ONE OPTION:**

☐ My child sees a dentist every 6 months. ☐ My child DOES NOT see a dentist every 6 months.

***PLEASE CHECK WHAT SERVICES YOU WOULD LIKE YOUR CHILD TO HAVE:**

☐	**Fluoride Varnish:** a protective coating placed on teeth to make the enamel stronger (up to 3 per year).
☐	**Sealants:** a plastic material placed in the deep grooves of permanent teeth to help prevent cavities.
☐	**Silver Diamine Fluoride (SDF):** liquid applied to tooth that slows decay and turns decayed area black.
☐	**Dental cleaning**: removal of plaque, calculus, & debris by using hand instruments and polishing cup. (Service **not** allowed if your child sees a dentist every 6 months, please keep seeing your regular dentist for routine care!)
☐	**Temporary Filling:** a temporary material placed in cavities to provide a short-term solution until a permanent filling can be placed. There is NO drilling.
☐	**Extraction of baby tooth:** a VERY loose baby tooth that needs removed because of gross decay or heavy plaque.

***MY CHILD'S RACE IS**: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

***MY CHILD'S ETHINICITY IS:** ☐ Hispanic ☐ Non-Hispanic

***PLEASE CHECK WHICH ONE APPLIES TO YOUR CHILD:**

☐ My child has no dental coverage.
☐ My child is covered under KanCare # _____
☐ My child has private dental insurance. (**Please fill out completely**)

Name on card holder: _____ Card holder DOB: _____

Relationship to student: _____ Card holder SSN: _____

Name of insurance company: _____

Address of insurance company: _____ City/State: _____

Policy #:_____ Group#:_____ Phone # on back of card:_____

KPCHC is covering the cost of services but requires all available dental insurance information for billing purposes. ***You will NOT be responsible to pay any portion of these services, but if you have dental coverage, your insurance carrier will be billed****. By signing below, you hereby authorize KPCHC to release the information requested by your insurance company necessary to process claims and authorize payment directly to KPCHC. Please check with your insurance company regarding coverage of fluoride applications if you choose to disclose this information. I confirm that the health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur. KPCHC staff will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by KPCHC and the facility/school who are responsible for medical treatment and/or record review. By signing below, I agree and understand.*

***PARENT/LAWFUL GUARDIAN INFORMATION:**

Signature _____ DOB:
Print First
Print Last
Address
Daytime phone # DATE:

SECTION 2 ➡

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SECTION 2 – CHILD HEALTH HISTORY

(Does not need filled out if your child is receiving only Fluoride Varnish)

Has your child ever had or now have any of the following? If you answer YES, please explain below:

YES	NO		YES	NO		YES	NO	
☐	☐	Heart trouble	☐	☐	Kidney Disease	☐	☐	Cancer
☐	☐	Tuberculosis	☐	☐	Bleeding problems	☐	☐	Lupus
☐	☐	Hepatitis B	☐	☐	Sickle Cell Anemia	☐	☐	TMD/TMJ
☐	☐	Hepatitis (other)	☐	☐	Skin disease	☐	☐	Artificial Joints Pins/Screws
☐	☐	HIV+	☐	☐	AIDS	☐	☐	Other Special Needs

Allergies:

☐	☐	Silver (rare)	☐	☐	Seasonal	☐	☐	Medications
☐	☐	Latex	☐	☐	Other			

Heart Problems:

☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse
☐	☐	Septic Defect	☐	☐	Artificial Heart Valve	☐	☐	Heart Disease

_____

_____

_____

Bleeding Disorder ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No If yes, is your child insulin dependent? ☐ Yes ☐ No

Asthma ☐ Yes ☐ No If yes, does your child keep a rescue inhaler with the nurse? ☐ Yes ☐ No

Special Considerations - Please circle and explain any that apply:

☐ Psychiatric ☐ Emotional Problems ☐ Physical Handicap ☐ Developmentally Delayed ☐ ADD-ADHD ☐ Autism ☐ Epilepsy

_____

Medications - Please list all medications your child is taking and dosage.

_____ _____

_____ _____

Is your child required by a physician to take a pre-medication prior to dental treatment? If yes, for what condition? ☐ Yes ☐ No

When did your child last visit a dentist? Please circle: ☐ In the past ☐ More than a year ☐ Never

Why did your child visit the dentist? Please circle:

☐ Checkup ☐ cleaning ☐ mouth pain ☐ filling ☐ tooth pulled ☐ other

Other Information: Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their specific needs:

PARENT SIGNATURE _____ **DATE** _____