KONZA PRAIRIE Community Health Center

LOCATIONS

Junction City
361 Grant Avenue
Junction City, KS 66441
Clinic: 785.238.4711
Pharmacy: 785.579.6146
Medical: 866.309.8893
Dental: 877.671.5661
Pharmacy: 866.533.3613

Manhattan
222 North 6th
Manhattan, KS 66502
Clinic: 785.320.7134
Pharmacy: 785.706.9833
Medical: 866.807.7393
Dental: 866.534.5933
Pharmacy: 866.562.9957

Chapman
111 East 5th Street
Chapman, KS 67431
Clinic: 785.922.6308
Medical: 866.309.8893

SECTION 1 – REGISTRATION

***STUDENT INFORMATION:**

First Name																			
Last Name																			

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

***PLEASE CHECK ONE OPTION:**

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

****Fluoride varnish only: Complete Section 1 only, including signature**
****For all other services: Complete Section 1 and 2 (health history), including signature**

****PLEASE PUT A CHECKMARK ✓ NEXT TO EACH SERVICE YOU WANT YOUR CHILD TO RECEIVE**

	Fluoride Varnish: a protective coating placed on teeth to make the enamel stronger. (**covered by KanCare 3x/yr)**
	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 holes in teeth 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.

***MY CHILD'S RACE IS**: □ American Indian/Alaska Native □ Asian □ Black/African American □ White
□ Native Hawaiian □ Other Pacific Islander □ Other
***MY CHILD'S ETHINICITY IS:** □ Hispanic □ Not 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 HIPAA 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.*

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"I consent for professional health care from KPCHC dental services. All services are voluntary, prohibited coercion and require no prerequisites. There are no court orders that prohibit me from signing this consent. I do hereby request and authorize the healthcare provider and practice staff to perform necessary services for the child named above"

***PARENT/LAWFUL GUARDIAN INFORMATION: please fill out completely and sign**

Parent/Guardian Signature:_____ Signer DOB:_____

Print First	
Print Last	
Address	
Daytime phone #	DATE:

(CONTINUE TO SECTION 2 HEALTH HISTORY IF STUDENT IS SIGNED UP ADDITIONAL SERVICES…**NO HEALTH HISTORY REQUIRED FOR FLUORIDE VARNISH)

Rev date: _____

By: _____

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Student Name: _____ **School:** _____

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? ☐ Yes ☐ No

If yes, for what condition?

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**_____