FORDLAND CLINIC

A BURRELL HEALTH AFFILIATE

11863 State Hwy 13, P.O. Box555 ● Kimberling City, MO 65686 ● 417-739-1995 ● Fax 417-739-1893
M-F 8am - 6pm ● Saturday & Sunday Closed

Fordland Clinic- Kimberling City will be at your child's school providing no-cost dental services (exam, x-rays, cleaning, fluoride), **Spring 2020**. Fordland Clinic is a non-profit clinic that accepts everyone, regardless of income or age. All children should receive preventative dental care twice a year. All children who are enrolled in your child's school, preschool through high school, are eligible for the School Based Dental Clinic. It's easy to get this no-cost dental care, just fill out this form (one for each child) sign it and send it back to the school.

All forms must be returned before dental care can be provided. Please make sure you fill out the forms completely and sign it on last 2 pages.

Each child needs a separate registration form.

If your child has an established dentist AND insurance, they may not be seen for exams, x-rays, or cleanings. If your child has dental insurance or Medicaid (MO HealthNet, or managed care plan), your insurance and/or Medicaid (MO HealthNet or managed care plan) will be billed for services performed. If you child does NOT have insurance or Medicaid (MO HealthNet or managed care plan), they will be seen in the school district and their care will be covered by a grant, courtesy of the Skaggs Foundation. You will not receive a bill for any services performed. Questions about this form or services to be rendered can be directed to Fordland Clinic at 417-739-1995.

[ ] My child sees a dentist regularly (every six months) and does not need school-based dental care from Fordland Clinic (do not fill out rest of form)

Today's Date ____/____/____

Child's Name: _____ Child's Date of Birth: ___ / ____ / ___

☐ Male ☐ Female ☐ Other Grade _____ Teacher_____

Street Address: _____

City _____ State _____ Zip Code _____ Phone number _____

Consent for Treatment: CHOOSE ONE OPTION AND IF FLUORIDE IS WANTED

Option 1 ___ I give my permission for my child to participate in the School Based Dental Clinic provided by Fordland Clinic, services include an oral exam, x-rays, and cleaning as needed.

I do ____ or do not_____ want my child to receive fluoride.

Options 2 ___ I do NOT give my permission for my child to participate in the School Based Dental clinic. (May still receive fluoride if selected above)

Parent/Guardian Information

Person Legally Responsible for Child: _____Relationship: _____

Home # _____ Cell #_____Email: _____

Dentist Information

Child's Dentist or Dental Clinic: _____

Phone number _____ Last seen _____

Insurance Information

Does your child have Medicaid or Medicaid managed care plan?

Medicaid or managed care plan #_____

Does your child have dental insurance?

Name of parent/guardian who carries insurance _____

Date of Birth of parent/guardian who carries insurance _____

Dental Insurance Company_____

Policy # or SSN of parent_____ Group #_____

I give Fordland Clinic staff authorization to discuss my child's treatment with my child's dentist, and to provide treatment plans and x-rays to my child's dentist, if needed.

I understand and acknowledge that HIV and Hepatitis testing may be performed upon my child or me without written consent, under the circumstances that a Fordland Clinic employee sustains a percutaneous mucous membrane or other exposure to my blood or other bodily fluids.

I request payment of authorized Medicaid &/or other Insurance benefits on my child's behalf for any services furnished to my child by Fordland Clinic.

_____

(Signature of parent/guardian) (Date)

Special Instructions:

_____

_____

Medical/Dental History Form

Your child's overall health, as well as any medications that your child takes could have an important impact on your child's medical/dental care. Please answer each of the following questions completely.

Have you ever been told your child needs antibiotics prior to dental work? Yes No

Has your child had any trouble with previous dental work? Yes No
If yes, please explain: _____

Medical History
Does your child have any of the following diseases or problems? If yes please check the corresponding box:

Yes	No		Yes	No	
❑	❑	Asthma	❑	❑	Convulsions/Epilepsy
❑	❑	Cancer	❑	❑	Tuberculosis
❑	❑	Hepatitis	❑	❑	Abnormal Bleeding
❑	❑	HIV/AIDS	❑	❑	Sinus Trouble
❑	❑	Hemophilia	❑	❑	Anemia
❑	❑	Diabetes	❑	❑	Rheumatic Fever
❑	❑	Allergies	❑	❑	Handicap/Disability
❑	❑	Congenital Heart Defect	❑	❑	Heart Murmur

Any other medical problems not listed (Please Explain):
_____

List any medications your child is taking (Please include prescription and non prescription drugs)
_____

Is your child allergic to or has he/she had a bad reaction to any of the following?

Yes	No		Yes	No	
❑	❑	Local anesthetics (Novocain)	❑	❑	Penicillin or other antibiotics
❑	❑	Latex	❑	❑	Sedatives, barbiturates, or sleeping pills
❑	❑	Aspirin	❑	❑	Iodine
❑	❑	Codeine or other narcotics	❑	❑	Other

Please sign below to ensure proper dental/ health care for your child.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to notify the healthcare provider office of any changes in my child's medical history.

_____
(Signature of parent/guardian) (Date)

Fordland Clinic is a non-profit, community-owned health center run by a local board of directors. The mission of Fordland Clinic is to improve the health of our community. The vision of the clinic is to serve as a model of quality, affordable healthcare by offering comprehensive medical, dental, mental health, prevention, and wellness services to everyone regardless of insurance and income.