NOCAC and Health Partners of Western Ohio Dental Department Dental Consent Form

Dear Parent,

NOCAC and Health Partners of Western Ohio (HPWO) Dental Department will be offering dental services to those children enrolled in NOCAC. Some dental services will be brought to your child's classroom. A dentist will provide the screenings and a dental hygienist will provide cleaning and fluoride varnish during the school year. A parent or guardian's signature is required for your child to receive services. Your signature will give NOCAC permission to transport your child for dental services as needed and it will also give HPWO permission to provide dental exams, cleanings/fluoride treatments, tooth extraction and any restorative procedures needed during this program year.

CHILD'S INFORMATION (Please Print)

Name: _____ Date of Birth: _____/_____/_____
Address: _____
Social Security # (REQUIRED): _____
Home Phone # _____ Dentist Name: _____
Gender: (Please Circle) Male Female Race: _____

HEALTH HISTORY

- **Has your child had any serious health problems? YES NO**
- **If yes, please explain _____**
- **Does your child have any allergies? YES NO**
- **Is your child allergic to latex? YES NO**

INSURANCE INFORMATION

This is information that HPWO must have completed in full in order to bill your insurance company for services provided.

Name of Insurance Company: _____
Name on Insurance Card (exactly as it appears): _____
If Insurance Cardholder is different than the patient, what is the relationship? _____
Subscriber I.D. # _____ Group #: _____
Effective Date on the card: _____ If patient is not the Insurance Cardholder, what is the Cardholder's Date of Birth? _____/_____/_____
Cardholder's Social Security # _____

PLEASE BRING YOUR CURRENT INSURANCE CARD SO THAT WE CAN MAKE A COPY FOR OUR RECORDS

PERMISSION

_____ YES, I would like my child to participate in this program.

_____ HIPPA information received.

_____ _____
Signature of Parent or Guardian Date