Community-based Dental Services

PERMISSION FORM

If you have questions, please contact LDCC at 253-539-7445.

FOR OFFICE USE ONLY:

Provider Initials: _____ Date:_____

Dear Parent or Guardian:

Lindquist Dental Clinic for Children, a local nonprofit organization, is offering community-based dental services. These services are **free** and you will **not** receive a bill. For your child to participate, please complete the information below and sign at the bottom of the form.

Which Dental Services are Provided?

A LDCC dentist or dental hygienist will look at your child's teeth and provide an **oral evaluation**. They will apply **fluoride varnish**, which is a thin protective coating to keep teeth healthy and strong. If your child's teeth are ready, the hygienist will place **dental sealants**, which protect teeth from developing cavities.

CHILD'S INFORMATION:

FIRST NAME	MI	LAST NAME	DOB: _____/_____/_____
GENDER OF CHILD:	**PLEASE CHECK:** ASTHMA___ DIABETES___ HEART CONDITION___ EPILEPSY___ LATEX ALLERGY___ OTHER ALLERGIES OR HEALTH CONCERNS:		

RACE/ETHNICITY	African American	Asian/Pacific Islander	Hispanic/ Latino	Native American	Bi-racial	White	Other:

PARENT/GUARDIAN INFORMATION:

FIRST NAME	MI	LAST NAME	DOB: _____/_____/_____
ADDRESS		CITY	ZIP
CELL PHONE NUMBER:			

Does your child have a regular dentist?	☐ Yes ☐ No ☐ Not Sure	Comment:
Has your child had a dental cleaning in the last 6 months?	☐ Yes ☐ No ☐ Not Sure	Comment:
Would you like help finding a dentist for your child?	☐ Yes ☐ No ☐ Not Sure	Comment:

This program is without cost to you, but if you have health insurance, we may bill them for services delivered. Please complete the insurance section below to ensure we have current information. If any costs are not covered by insurance, they will be covered by grants. No out-of-pocket expense will be billed to any student or family participating in the program. The screening will not be billed as one of your child's two yearly dental exams.

PLEASE PROVIDE YOUR INSURANCE INFORMATION BELOW OR LEAVE BLANK IF NO INSURANCE:

Apple Health/Medicaid/DSHS	Please provide child's 9-digit number on card: _____
Tricare/Military Dental	Subscriber Name: _____ DOB:_____ Subscriber ID#: _____
Private Insurance: *add name* _____	Subscriber Name: _____ DOB:_____ Group/Policy #: _____
Optional Pay (not required)	If you'd like to pay out-of-pocket for services , please call LDCC at 253-539-7445.

BY SIGNING THIS FORM, YOU AGREE TO THE SERVICES CHECKED: ☐ **Oral Eval** ☐ **Fluoride** ☐ **Sealants**

SIGNATURE OF PARENT/GUARDIAN: **DATE:**

Lindquist Dental Clinic for Children adheres to all Health Insurance Portability and Accountability Act 1996 (HIPAA) standards. We are committed to protecting the privacy of your child's health information. The HIPAA requires all health care records to be kept confidential. By signing above, we have your permission to communicate with health staff regarding your child's dental needs and health care information.