NORTH FLORIDA MEDICAL CENTERS, INC

Consent for Treatment Form (Please Sign where indicated)

Return to student's teacher

I give **NORTH FLORIDA MEDICAL CENTERS, INC** permission to provide preventive dental services for my child, _____ and to collect payment from Medicaid, on my behalf and
(Your Child's Name)
To allow the dentist of my choice to obtain my child's dental record.

Treatment may include a limited dental examination, assessment, professional cleaning, fluoride varnish, and/or dental sealants. These dental services are an important preventive measure to reduce cavities for your child. Along with good brushing and flossing, your child should visit the dentist every 6 months for a dental check up. These services are not a substitute for a comprehensive dental examination. Diagnosis for caries (cavities), soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions can only be completed by a dentist in the context of delivering a comprehensive dental examination.
Children, who do not have Medicaid, may be sponsored through an Emerald Coast Dental Hygiene Association Outreach Program secured to help the uninsured. Eligible families may be given an opportunity to enroll their children into the Medicaid program during this event. Children identified as needing follow up dental services will be referred to a dental home (provider).

By signing below, I am indicating that I have read and understand the contents of the General Information/Medical History form accompanying this Consent for Treatment form, that I understand the terms of the consent agreement, that I have the legal authority to give this consent for the child, and that I have received a copy of the NORTH FLORIDA MEDICAL CENTERS INC. Notice of Privacy Practice. Providing the insurance information will allow NORTH Florida Medical Center to file insurance, if applicable, on your behalf. I/We authorize payment of dental benefits to North Florida Medical Center. This consent is valid for 24 months from date of signature.
Parent or Legal guardian Signature: _____Date: _____

Insurance Information – If Applicable

Child's Social Security number _____

Medicaid Information

Child's Medicaid recipient ID __ __ __ __ __ __ __ __ __ __

Head of Household Name: _____
Does your child have any other insurance? Please check if applicable.

	Insurance Carrier:	Claims Address:	Insured ID #
o	**Kidcare**	_____	_____
o	**Healthy Kids**	_____	_____
o	**Delta Dental**	_____	_____
o	**Blue Cross/Blue Shield (Dental)**	_____	_____
o	**Medicaid**	_____	_____
o	**NO INSURANCE**		

NORTH FLORIDA MEDICAL CENTERS, INC

General Information (Please Print)

Child's Name: _____ **Date of Birth** ___/____/_____
Last First Middle Initial Month/Day/Year

Child's SSN:_____ **Address:** _____
Street City State Zip Code

Parent/Guardian Name: _____**Address**_____

Home/Contact phone: _____**School Name:** _____**Teacher Name:**_____

Child on Free or Reduced Lunch Program? Y N

Do you receive Medicaid? Y N **Child Medicaid number** _____**Sex:** M F

Race: Circle all that apply! [American Indian/Alaska] [Asian] [Hawaiian] [Black] [White] [Unreported] [Pacific Islander/Other]

Ethnicity: [Hispanic Latino] [Non-Hispanic] **Homeless?** Y N

Is anyone in your family an Agricultural Worker? Y N **Seasonal?** Y N **Migrant?** Y N

Health Information

[Yes] [No] Does your child have any serious health problems? If yes, please explain: _____

[Yes] [No] Does your child have asthma?

[Yes] [No] Has your child ever had rheumatic fever or rheumatic heart disease?

[Yes] [No] Has your child ever been diagnosed with a heart murmur?

[Yes] [No] Is your child presently taking any medication? If yes, please list: _____

[Yes] [No] Have you ever been told by a dentist or physician that your child needs to take antibiotics (Penicillin) before dental care?

[Yes] [No] Is your child allergic to any medications? If yes, please list: _____

[Yes] [No] Is your child allergic to latex?

[Yes] [No] Has your child ever been examined by a dentist? If yes, date of last exam: _____
What was the reason for the visit? _____

[Yes] [No] During the last 12 months, was there a time when your child needed dental care and was unable to receive dental services?

If yes, please explain why._____

Name of your regular dentist: _____

HIPAA Notice of Privacy Practices

You have been given a detailed Notice of Privacy Practices for North Florida Medical Centers Inc. This is a summary of the detailed information: As your child's healthcare providers, we may use your child's health information to provide him/her with health care services. We may use and disclose health information about your child's care, if necessary, for center operations in order to ensure all our patients continue to receive quality care. As the parent or guardian of your child (our patient) you have the right to inspect and copy the medical information that we maintain, amend or correct that information, request that we communicate confidentially, restrict certain uses and disclosures of your child's health information, and the ability to file a complaint with us if you feel your rights have been violated. If you have any questions, concerns or complaints about the Notice or your medical information, please contact the Privacy Officer at (850)385-4494_____.

I have read and understand the Summary of Privacy Practices, and give permission for my child to participate in the today's Event.

_____

Parent Signature **Please print Name** **Date**

Medical History reviewed_____

Provider signature **Date**