



# DENTAL REGISTRATION & CONSENT FORM

## SCHOOL-BASED HEALTH CENTER

This document must be completed by the parent or legal guardian for consent of healthcare services to be provided to the student listed at the School-Based Health Center (SBHC). This document will be effective upon date signed, until the last active day of school, unless otherwise requested in writing to the School-based Health Center (SBHC).

### STUDENT INFORMATION

<b>LAST NAME</b>		<b>FIRST NAME</b>		<b>MIDDLE INITIAL</b>		<b>BIRTHDATE</b> mm/dd/yyyy	
<input type="checkbox"/> Male <input type="checkbox"/> Female							
<b>GENDER</b>		<b>SCHOOL ATTENDING / SCHOOL-BASED HEALTH CENTER LOCATION/ GRADE</b>					
<b>ADDRESS (STREET)</b>				<b>CITY</b>		<b>STATE</b>	<b>ZIP CODE</b>
<b>MOBILE PHONE</b>		<b>HOME PHONE</b>		<b>E-MAIL</b>			

**RACE** (please check ONE):

- Native Hawaiian
- American Indian/Alaska Native
- Asian Indian
- Black/African American
- Chamorro
- Chinese
- Chuukese
- Filipino
- Japanese
- Korean

- Laotian
- Marshallese
- Micronesian
- Samoan
- Thai
- Tongan
- Vietnamese
- Guamanian
- Other Pacific Islander
- White/Caucasian (Including Portuguese)

**ETHNICITY** (please check ONE):

- Cuban
- Hispanic or Latino
- Mexican, Mexican American, Chicano
- Not Hispanic or Latino
- Puerto Rican

**MILITARY DEPENDENT** (please check ONE):

- Yes
- No

### STUDENT HEALTH HISTORY

ALLERGIES TO FOOD OR MEDICATIONS		DISABILITIES	
MEDICATION/SUPPLEMENT	DOSAGE	MEDICATION/SUPPLEMENT	DOSAGE
MEDICATION/SUPPLEMENT	DOSAGE	MEDICATION/SUPPLEMENT	DOSAGE

**CHECK ANY OF THE FOLLOWING THAT APPLY TO THE STUDENT'S HEALTH HISTORY:**

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> ADHD              | <input type="checkbox"/> Depression        | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Sickle Cell Disease                  |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hearing/Vision   | <input type="checkbox"/> Latex Allergy     | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Growth Problems  | <input type="checkbox"/> Liver Disease     | <input type="checkbox"/> Stomach Problems                     |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Pregnancy (Teens) | <input type="checkbox"/> Weight Problems                      |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seasonal Allergy  | <input type="checkbox"/> Other: _____                         |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> HIV+ / AIDS      | <input type="checkbox"/> Seizure Disorder  |   |

<b>DOCTOR/PEDIATRICIAN/PROVIDER</b>	<b>PHONE NUMBER</b>
<b>PHARMACY</b>	<b>PHONE NUMBER</b>



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## SCHOOL-BASED HEALTH CENTER

### PARENT OR LEGAL GUARDIAN INFORMATION

#### MOTHER'S INFORMATION

Yes  No

LAST NAME

FIRST NAME

BIRTHDATE

LIVES WITH YOU

MOBILE/HOME PHONE

WORK PHONE

E-MAIL

#### FATHER'S INFORMATION

Yes  No

LAST NAME

FIRST NAME

BIRTHDATE

LIVES WITH YOU

MOBILE/HOME PHONE

WORK PHONE

E-MAIL

#### LEGAL GUARDIAN INFORMATION

Yes  No

LAST NAME

FIRST NAME

BIRTHDATE

LIVES WITH YOU

MOBILE/HOME PHONE

WORK PHONE

E-MAIL

#### EMERGENCY OR ALTERNATIVE CONTACT INFORMATION

LAST NAME/FIRST NAME

PHONE

RELATIONSHIP TO STUDENT

#### DENTAL INSURANCE / GUARANTOR INFORMATION

HEALTH INSURANCE PLAN

POLICY NUMBER

GROUP NUMBER

NAME (Last Name, First Name, Middle Initial)

BIRTHDATE

EMPLOYER

ADDRESS

CITY

STATE

ZIP CODE

MOBILE/HOME PHONE

WORK PHONE

E-MAIL

**FINANCIAL INFORMATION** (We collect this information to determine eligibility for programs such as financial assistance and medical or dental coverage options for uninsured or underinsured patients; you may also qualify for dental services at low or no cost.)

Yes  No

NUMBER OF PEOPLE IN HOUSEHOLD

GROSS MONTHLY FAMILY INCOME

ARE YOU HOMELESS

IF YOU ARE HOMELESS, PLEASE CHECK ONE:  Shelter  Transitional  Doubling Up  Street



# DENTAL REGISTRATION & CONSENT FORM

## SCHOOL-BASED HEALTH CENTER

### PARENT/LEGAL GUARDIAN CONSENT FOR STUDENT

I, the parent/legal guardian of said student, give consent for the student to receive all dental services at the School-Based Health Center Dental Clinic, including x-rays, teeth cleaning, sealants and restorative care (such as fillings for tooth decay).

I understand that SBHC is operated by Wahiawa Health Center in cooperation with the school, it is not part of or directly operated by the School. I understand that SBHC is operated by WHC and certain records about the student and the student's treatment shall be kept in written and computerized form and may be reviewed by other providers at WHC as needed.

I understand that the student may be seen by a trainee/student who is identified as such and that all services provided will be supervised by a licensed provider. I have the right to refuse services by a trainee/student.

**I understand that no student will be denied access to health services due to inability to pay.** As in any health center, **if your child is insured, insurance will be billed.** If there are co-payments, co-payments will be the responsibility of the parent or legal guardian. Wahiawa Health does not have the authority to waive co-payments required by your insurance. **If you are unable to pay your co-pay or dental bill, please contact the SBHC staff and we can further assist you. No student will be denied access to dental care due to inability to pay.** If examination findings indicate the need for treatment or procedures beyond routine dental services, Wahiawa Health Center Dental Clinic will notify the parent/legal guardian regarding recommended treatment options. The patient may be referred to a dental specialist or other qualified provider for further evaluation and care when appropriate.

I understand that SBHC may release information regarding treatment to third party payers for billing purposes. I agree to pay my portion of the students' costs, if any, associated with the services received.

I am the parent/legal guardian-representative of the student. I understand that if guardianship or representation changes, a new consent must be signed by the legal guardian-representative. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the student may be shared between the medical provider and the alternative contact.

I understand that this consent form is valid for the student's entire enrollment for the school year 2026-2027 or until I provide SBHC staff with written directions otherwise.

Please list dental services that you **DO NOT** want your child to receive: \_\_\_\_\_

### CONSENT TO ADMINISTER MEDICATION

I agree to my child receiving any medication(s) required for his/her care at the School-Based Health Center, unless otherwise indicated below. I understand that medications, or a generic equivalent, will only be administered by a Dental Assistant, Dental Hygienist or Dentist.

**Please check this box if you want the provider to call you before administering any medications.**

### CONSENT TO RELEASE INFORMATION

I give authorization for Wahiawa Health Center to release to the school copies and/or updates of the student's services received at SBHC Dental Clinic.

### ACKNOWLEDGEMENT OF HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information. A copy of this policy is located at the School-Based Health Center or can be obtained from our sponsoring center's website, <https://wahiawahealth.org/notice-of-privacy-practice/>. You must sign below, indicating that you have received notification on how to obtain a copy of our HIPAA policies prior to the student receiving services.

\_\_\_\_\_  
PRINT NAME OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
PARENT/LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE