Health Partners of Western Ohio
Dental & Vision Outreach Consent Form
PLEASE SIGN AND RETURN TO SCHOOL

Our Outreach Team will be coming to your school and offering vision and dental services. Regular dental and vision check-ups are an important part of overall health. **We will bill Medicaid and Private Insurance.** The dental visit will be considered a preventive visit through your insurance company. If your child has no health coverage there will be NO charge. Our center can help sign you and your family up for insurance, if eligible. The program is open to all children.

YES, I give my informed consent for my child to participate in the School-Based Outreach Program.

Please check which services you wish for your child to participate in:

☐ Dental Only ☐ Vision Only ☐ Both Dental and Vision

Please complete the rest of this form, **PRINT & SIGN at the bottom** and return it to school.

Child's First Name: ______________ Child's Last Name: ______________

Child's Date of Birth: ____/____/____ ☐Female ☐Male Child's SSN: ____-____-____

School Name: ______________ Grade ____ Rm # ____ Teacher: ______________

Address: ______________ City: ______________ Zip: ______

Phone: ______________ Email: ______________ County: ______________

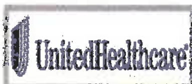
Race/Ethnicity (Circle all that apply): White Black/African American Hispanic Asian Pacific Islander/ Hawaiian Native American/Alaskan Native Other

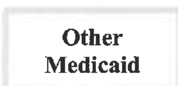
Does your child have any serious health problems? ☐Yes ☐ No If YES, please explain: ______________

Does your child have any allergies? (i.e.: acrylics/plastics/bees/latex, etc.) ☐Yes ☐ No Please List:

Medicaid Plans

Circle plan your child has and fill in Billing Information





Member ID # ______________

Medicaid # (MMIS) ______________

Private Insurance Plans

Name of **Dental** Plan: ______________

ID # ______________ Group # ______________

Insurance Holder Name: ______________

Insurance Holder DOB: ______________

Insurance Holder SSN: ______________

Claim Address: ______________ Phone # ______________

Employer: ______________

Name of **Vision** Plan: ______________

ID # ______________ Group # ______________

Insurance Holder Name: ______________

Insurance Holder DOB: ______________

Insurance Holder SSN: ______________

Claim Address: ______________ Phone # ______________

Employer: ______________

I have read and completed the information on this consent form and my signature below gives consent for treatment and is valid for the life of the student. I have read and understand the Notice of Privacy Practices on the back of this form and know that a copy is available from the school office or hpwohio.org. This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to the Health Insurance Portability and Accountability Act. I authorize Health Partners staff to provide dental and vision services at school to the above-named child. I authorize my child to be treated through both in-person and remote evaluation. I understand that appropriate technologies will be utilized when the provider is in a location remote from my child. The dental services include an exam, cleaning, fluoride, sealants, and the application of Silver Diamine Fluoride as needed. (The use of Silver Diamine Fluoride may discolor any cavities to a brown or black color. SEE BACK FOR DETAILS.) The vision services include a full vision exam, dilation drops as necessary, and prescription glasses. I give consent for Health Partners staff to collaborate with school staff especially when additional dental and/or vision treatment is necessary to ensure my student receives follow-up care.

Parent/Guardian Signature ______________ Date ______________

Print Parent/Guardian Name ______________

To find a medical or dental office near you, please visit our website at www.hpwohio.org.

Dental Outreach: 567-825-0226 Vision Outreach: 419-516-0799