WHITE HOUSE
CLINICS

Dear Parents,

White House Clinics is proud to be part of the Garrard County School community. We are committed to supporting your students' well-being and are eager to provide access to much needed dental services. Our state-of-the-art mobile dental bus and experienced care team can offer a wide range of services including complete exams with x-rays to detect decay and abnormalities, cleanings, application of fluoride, preventative sealants, fillings, and extractions as needed.

Our mobile dental team, led by Dr. Tina Knopp, will be scheduled at the school multiple days each month to ensure access and continuity of care for your student. In the initial visit with our care team, your student will receive a comprehensive dental exam, x-rays, sealants, and cleaning. Our team will put together an oral hygiene report card containing information about the visit, recommendations, and all services performed during the visit to send home with each student. During the exam the dentist may determine that additional treatments such as fillings or extractions are needed. If the dentist recommends any additional treatments, a member of our care team will contact you to explain the treatment plan and provide consent forms for these services.

It is important that children see a dentist on a regular basis to stay healthy and avoid toothaches, cavities, and other problems that impact school performance. As a student at Garrard County schools, your student will have access to dental services provided on the mobile bus. Prior to a scheduled day at your student's school, a member of our team will always attempt to reach out to determine if you would like your student added to the schedule.

Our team will be routinely coming to the school, allowing for any additional treatment to be completed on the bus. As our team will be proactively communicating treatment plans and confirming consent, it is important to provide contact information so that our team can reach you or a trusted emergency contact if needed. Our team will also be available for questions you may have regarding your student. The attached consent form is effective for the entire school year, and a separate form is needed for each of your children. If you have questions about the consent form or services provided you can reach a member of our care team by calling 855 WHAPPTS (855-942-7787).

Again, on behalf of the White House Clinics, we are delighted to be a part of this wonderful learning environment and look forward to contributing to the health of the Garrard County School system.

Best Regards,

Stephanie Moore

Stephanie Moore, MPA, CMPE
Chief Executive Officer

WHITE HOUSE CLINICS

Dental History and Consent for Mobile Oral Health Services

This document provides important dental health information about your student for the dental care team. Please include all serious health conditions, allergies, and any medications your student is taking along with the contact information for the parent/guardian or trusted emergency contacts that we can call if your student has an urgent dental concern. This form must be completed and signed for your student to receive dental health services.

STUDENT INFORMATION

Grade Level: _____ **Homeroom/Teacher:** _____

Student's Full Name: _____ **Date of Birth:** _____

Student's Social Security #: _____ **Sex**: ☐ Male ☐ Female ☐ Other: _____

Race:
☐ Black ☐ White ☐ More than one Race ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ American Indian/Alaska Native ☐ Samoan ☐ Choose not to answer

Ethnicity:
☐Not Hispanic ☐Mexican ☐Mexican American ☐ Chicano ☐Puerto Rican ☐Cuban ☐Another Hispanic, Latino/a, or Spanish origin
☐Choose not to answer

Street Address: _____ **City, State, Zip:** _____

DENTAL HEALTH HISTORY INFORMATION

Has your student ever had any of the serious health conditions listed below? ***(circle all that apply)***

☐ Diabetes	☐ Asthma	☐ Seasonal Allergies	☐ Seizure Disorder	☐ Behavior Problems	Other: _____

Is your student allergic to any food or medications? If so, please list: _____ ☐ **No Allergies**

Is your student currently taking any medications? If so, please list: _____ ☐ **No Medications**

Has your student complained of any dental pain? If yes, how long? _____

Does anyone in the student's home smoke? _____

Student's Past Procedures or Surgical Treatments:

STUDENT'S DENTAL INSURANCE

Does your student have dental insurance?	☐ Medical Card	☐ KCHIP	☐ Private	☐ None

Insurance Name: _____ **Policy Holder:** _____

Policy Number: _____ **Policy Group:** _____

Student's primary dental provider*? _____ **Date of Last Check-Up:** _____

**If the student already sees a dentist on a regular basis, the parent or guardian should continue to arrange dental care through that provider. The treatment provided through this mobile dental clinic may affect insurance benefits (as with any dental office) as treatment services will be billed to your dental insurance provider.*

CONTACT INFORMATION			
If your student has an urgent dental concern and may need to see a provider for further treatment, we will contact you to let you know what symptoms your student is having and discuss the available options. Please list below the numbers where we can try to reach you regarding your student's health.			
PARENT/GUARDIAN CONTACT INFORMATION			
Parent/Guardian #1:		Parent/Guardian #2:	
Cell Phone:		Cell Phone:	
Alternate Phone:		Alternate Phone:	
EMERGENCY CONTACT INFORMATION			
Name:		Name:	
Relationship:		Relationship:	
Cell Phone:		Cell Phone:	

CONSENT FOR HEALTH SERVICES & ASSIGNMENT OF BENEFITS

I authorize White House Clinics' affiliated dentists and /or dental hygienists to provide the following dental services as needed: exam, cleaning, x-rays, fluoride, and sealants to my student. I understand that no guarantees are being made as to the effect of any exam or treatment on myself or my student. I authorize the school health clinic to release health information about my student to his or her primary medical or dental providers. I also understand that the information obtained for the school dental exam will be released to my student's school. If my student has Medicaid or K-CHIP, I also authorize the school clinic to release this information to Medicaid/K-CHIP so that the Medicaid/K-CHIP can be billed for visits to the school clinic. I also understand by signing this consent, I acknowledge that I have been **provided access to the White House Clinics' Privacy Notice** (https://whitehouseclinics.com/patient-forms/privacy-notice/). Paper copies are available upon request at any White House **Clinics' location or on the dental bus. This authorization will expire one year from the date of signature.**

By signing below, you are consenting to services for the student named in this consent form. If you do not consent at this time, you will be required to provide consent before your student can receive services. A member of our team will always call before delivering any service.

_____ _____

Signature (Parent, Legal Guardian, or Emancipated Student) Date