WCMCA Head Start Dental Day Record / Permission Form

Child's Name_____ **MA MnCare PrimeWest Blue Plus Other (circle all that apply)**

DOB_____ **Gender; MALE FEMALE** **Insured ID #**_____ **MnCare Subscriber ID**_____

Parents/ Guardian_____ **Private Insurance Co. name** _____**ID#**_____

Address_____ **Private Insurance in name of**_____ **DOB** _____

Phone_____ **Private Insurance Co address** _____

Medical History:

Physician/Clinic_____

Medications:_____ **Allergies:**_____

Is Child being treated for anything at this time? Yes No **If yes, What**_____

Recent Hospitalization: _____ **Surgeries:**_____

Notice of Privacy Practices

You have privacy rights under the Minnesota Government Data Practice Act and the Federal Health Insurance Portability and Accountability Act (HIPPA). These laws protect your privacy, but also let us give information about you to others if a law requires it. A complete notice with all details is available upon request from the following provider of services.

We will use or disclose your personal health information only for the purposes for your treatment, payment of services provided to you, or for healthcare operations of Head Start and Public Health.

Permission

I give the CARING HANDS dental clinic permission to provide for my child's care:

Circle all that apply: ***Oral Health Exam*** ***Cleaning*** ***Fluoride Varnish*** ***Oral Hygiene Instructions***

I have reviewed the Notice of Privacy Practices.

Parent/ Guardian Signatures:_____**Date:**_____

- Date:_____Provider Signature**:**_____ Referral: YES NO

Oral Health Assessment Cleaning Fluoride Varnish Oral Hygiene Instructions

Notes:_____

- Date:_____Provider Signature**:**_____ Referral: YES NO

Oral Health Assessment Cleaning Fluoride Varnish Oral Hygiene Instructions

Notes:_____

FES's:

1. **Make copy for Caring Hands, the parent and the Health Coordinator on the day of the varnishing.**
2. **Keep main copy for your file to use each dental day.**