ATCHISON COMMUNITY HEALTH CLINIC – SCHOOL BASED DENTAL SERVICES

NEW PATIENT STUDENT INFORMATION

Student Last Name (Legal):	Student First Name (Legal):	MI:	Preferred Name:

Student Date of Birth:	Student Sex at Birth: ☐ Male ☐ Female	Student Gender Identity: Innermost concept of self as male, female, both, or neither ☐ Male ☐ Female ☐ Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Something else: …… ☐ Choose not to disclose	Student Race: ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black / African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White / Caucasian
Parent Home Phone #: □ Permission to leave voicemail	Parent Cell Phone #: □ Permission to leave voicemail		
Is the Student homeless? ☐ Yes ☐ No	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic		

Student Address:	City	State	Zip:

KANSAS MEDICAID BENEFITS

Does the student have KanCare? ☐ Yes ☐ No	☐ KS Medicaid ☐ Sunflower ☐ United Healthcare ☐ Aetna
KanCare policy ID #:	

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company:	Primary Dental Insurance Address:	
Subscriber First and Last Name:	Subscriber Date of Birth:	Subscriber Social Security #:
Insurance Policy #:	Insurance Group #	

RESPONSIBLE PARTY / PARENT / GUARDIAN INFORMATION

Last Name:	First Name:	MI:
Social Security #:	Phone Number:	Date of Birth:
Email Address:		

EMERGENCY CONTACT

Name:	Relationship to Student:	Phone number:

CONSENT TO TREAT

Your child's school has agreed to work with Atchison Community Health Clinic (ACHC) to provide space for dental services. I give ACHC permission to provide dental services to my child. I acknowledge that the Privacy Practices were and are available for my review. I hereby state, to the best of my knowledge, the above information is complete and correct. I authorize ACHC to submit all services to my insurance company and to collect payment on my behalf. I understand that I am responsible for any co-pay, deductible or non-covered services. I understand ACHC offers a sliding fee discount. If interested in applying for the discount or you have questions about your bill it will be necessary to call the ACHC billing office at 913-367-4879.

Parent/Guardian Name:

Parent/Guardian Signature:	**Date:**

2021 ANNUAL FEDERAL POVERTY GUIDELINES

Please note, the federal government requires us to ask you for the following information. It is used for government reporting purposes only. No identifying information will ever be disclosed, including name, and we will not use this information for any other purpose.

*****PLEASE CIRCLE YOUR HOUSEHOLD SIZE AND INCOME*****

Clear All Household Selections

1 Person in Household	2 People in Household	3 People in Household	4 People in Household
$0.00 - $12,880	$0.00 - $17,420	$0.00 - $21,960	$0.00 - $26,500
$12,881 - $15,971	$17,421 - $21,600	$21,961 - $27,230	$26,501 - $32,860
$15,972 - $19,191	$21,601 - $25,955	$27,231 - $32,720	$32,861 - $39,485
$19,192 - $25,760	$25,956 - $34,840	$32,721 - $43,920	$39,486 - $53,000
$25,761	$34,841	$43,921	$53,001

5 People in Household	6 People in Household	7 People in Household	8 People in Household
$0.00 - $31,040	$0.00 - $35,580	$0.00 - $40,120	$0.00 - $44,660
$31,041 - $38,489	$35,581 - $44,119	$40,121 - $49,748	$44,661 - $55,378
$38,490 - $46,249	$44,120 - $53,014	$49,749 - $59,778	$55,379 - $66,543
$46,250 - $62,080	$53,015 - $71,160	$59,779 - $80,240	$66,544 - $89,320
$62,081	$71,161	$80,241	$89,321

☐ Check here if your child has a dental home and you DO NOT want your child to have dental services performed at your child's school.

Medical History Information

When did your child last visit a dentist?
- ☐ In the past year
- ☐ More than a year ago
- ☐ Never

Why did your child visit the dentist?
- ☐ Checkup
- ☐ Cleaning
- ☐ Mouth Pain
- ☐ Filling
- ☐ Tooth Pulled
- ☐ Other

Medical History:
- ☐ Heart murmur
- ☐ Seizure Disorder
- ☐ Artificial Heart Valve
- ☐ Heart Disease
- ☐ Artificial Joints, Pins, Screws
- ☐ Congenital Heart Disorder
- ☐ Other:
- ☐ Autism
- ☐ Asthma
- ☐ Diabetes
- ☐ Hepatitis

Allergies:
- ☐ Latex
- ☐ Amoxicillin/Penicillin
- ☐ Other:

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? ☐ Yes ☐ No
If yes, for what condition:

Does your child have special needs? ☐ Yes ☐ NO If yes, please explain:

Surgeries/Hospitalization/Other medical conditions?

Is your child currently taking medication? ☐ Yes ☐ No If yes, please list the medication(s).

Other information – Please tell us anything we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs:

I confirm the above information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature:	Date: